#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Anderson Garx 11:52A JUN 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death KA HOOKIN MIMORE CENTER If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 M 2 □ F 37 Yrs 214-84-0771 1-22-1962 Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 M Yes 2 □ No n/a Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3636 Roberts Place 21224 USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11 Meritel Status 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Specify: White 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) disabled Carpenter 10th 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lonnie Anderson Sr. Ruth Swiger 19e. Informent's Neme/Reletionship (Type, Print) parents 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3636 Roberts Place, Baltimore, Maryland 21224 Mr&Mrs. Lonnie Anderson 20b. Place of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 7/2/99 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) Oaklawn Cemetery 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Joseph N. Zannino Jr. Funeral Hm 263 S. Conkling St. Baltimore, Maryland 21224 Jares & 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. Listonly one cause on each line. Approximete Intervel Between Onset end Death Immediate Cause (Final disease or condition resulting in deeth) ears stension Due to (or es e consequence of) Due to (or es e consequence of)

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

MD

Director

Funeral

p

Completed

8

**Funeral** 

Director

tem 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic avent, the Medical Examinar must be notified at

Hygiene.

permit. Pages 1 and 2 should be filed Department of Health and Mental Hygii Important: if item 27 is marked other i any injury or other traumatic avant.

altimore, Maryland 21215-0020

P.O. Box 68760

Records,

Division of Vital

certificate be

Physician/Medical

by

Completed

Be

2

edical Certification;

certificate

After this

afor Attending P after death.

I Director: After to in by the funers

To the Hospital or within 24 hours after of To the Funeral Direct To miletaly filled in by

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

23b. Did tobacco use contribute to the cause of death? 1 XYes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

25. Wes case referred to medical examinar?

Hospitel: 1 Inpatient 28a. Dete of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

26. Place of Deeth (Check only one) Other: 4 | Nursing Home 5 | Residence 6 Other (Specify) Dialy515 28d. Describe how injury occurred

1 Yes

1 Yes 20 No

18 Yes 2□ No 27. Menner of Death

5 Pending Investigation 6 Could not be determined

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

28e. Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a, Certifier

1 Neturai

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated.

29b. Signeture end title of certifier

29c. License number

29d. Dete signed (Month, Day, Year)

30. Nema and address of person who completed cause of death (ttem 23a) (Type, Print)

; 4940 Eastern Ave; Baltimore Edward S. Kraus MD 31. Date filed (Month, Dey, Year)

State Registrar

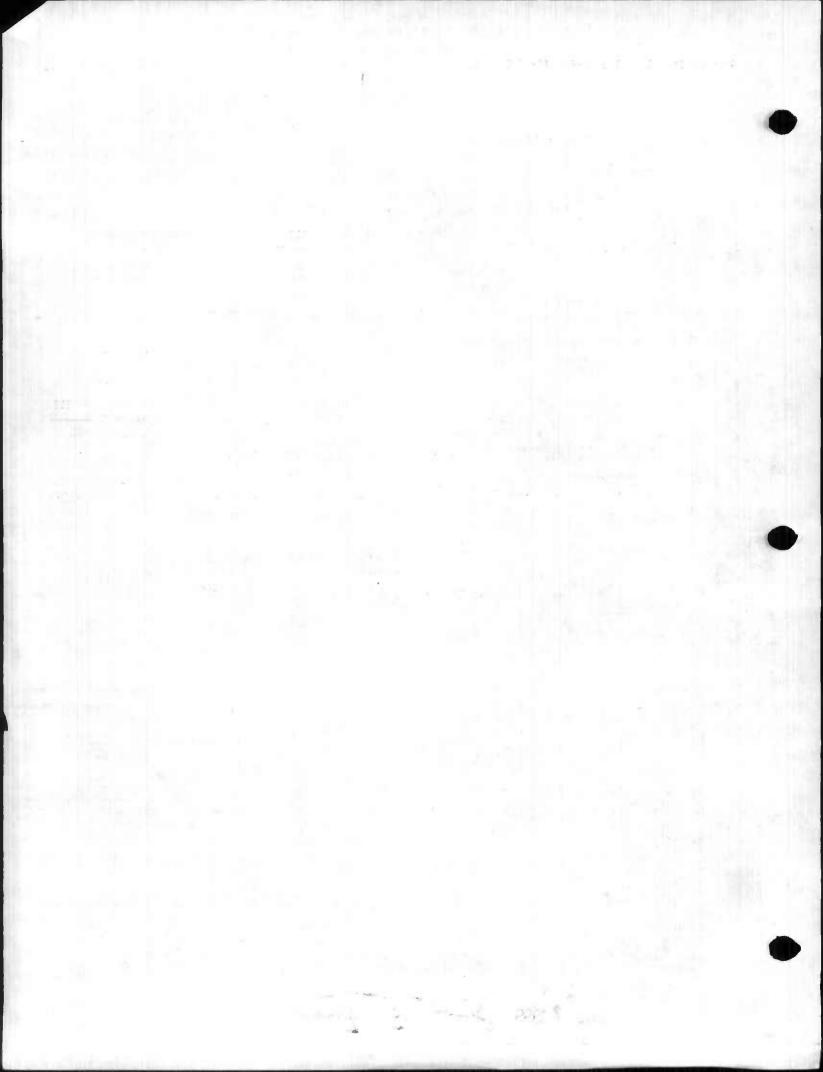
0 2 1999 JUL

32. Registrer's Signeture

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

ended Item#	10f ,19b per	FH G77	State of 3 7/2/99					lealth a Death	ind M		giene 9	9 2	1002	
sician	int's Neme (First, Mic	ddle, Last)			BU	JCKMAI	V			2. Data of De Month JULY 1	Day	Year	3. Time of D 7:15 F	
ral 5. Social S	7233 PAF	RK HE	IGHTS A	VENUE Age (In yrs.	#D last birthday)	If Under	1 Year Days	BALT] If Under:	MORE	cation of Death	4c. Count	9. Birth	Birthplace (State or Fo Country)	
	-32-6785 sidence of Decedent 10b. Cour			94	Yrs.	- adian				APR.10	,1905		MD	
MD MD	N/				TIMORE	E		21.00					10d. Inside City 1 X Yes 2	
723	of and Number 3 PARK HE	GHTS	AVENUE	#D		10f. Zip	Code	21209 21209			10g. Citizen of U.S.		intry?	
3 □ W	I Stetus ever Merried 2 Mi idowed 4 Divorc	arried	2. Was Deced Armed Forc 1 Yes 2 If Yes, Give Yeer or Dete	es? ⊠No	1	Wes Dece If Yes, spe 1 Yes	city Cuba	ispanic Origin, Mexican  Specify:	gin? (Spe , Puerto l	cify Yes or No Rican, etc.)	Bk	Race - American Indian,     Black, White, etc.  Specify: WHITE		
Elemen	15. Deced (Specify only high tery/Secondery (0-12 12	hest grede	cation completed) College (1-4	lor 5+)	(Give	dent's Usu kind of wo DO NOT u	se retired	during most	of working	ng	16b. Kind of t		ndustry	
17. Fether JOSE	's Neme (First, Midde PH	le, Last)		BUCKMAN  18. Mother's Name (First, Middle, Maiden Su FANNIE  19b. Mailing Address (Street and Number or Rural Route Number, City or To							Maiden Suma	rmame) FREEMAN		
	ment's Neme/Reletion			R									21209 21209	
1 💢 E	od of Disposition Jurial 2 Cremetio Jonetion 5 Other		emovel from St	ete	Plece of Disponentery, cred	metory or c	other plac		RD 7	Date /2/99	20c. Location	- City or T		
21. Signa	ture of Juneral Service	ce License	1	7				ss of Facility	SC		NSON &		, INC.	
Immediat	Enter the disease, k, or heart feilure. L     Ceuse (Finel r condition n death)	or complic ist only one a.	cetions that cau e ceuse on eed	PU						r respiratory e		1	Approximete Interval Betwee Onset and De	
resulting	ally list conditions, ding to immediate niter Underlying isease or Injury ad events n death) Last	6.		Por Due to (d	or as a consecutive as	quence of):	250	D	75 £	5057	5			
Part II. Oti	ner significant condi	d. Itlons conf	ributing to deal							d tobacco use contribute to the caus				
	Nas	CO	0							perfo	an autopsy ormed?	0	Vere autopsy fin vailable prior to ompletion of cau f death?	
	ase referred to medi-	_						26. Place	of Death	(Check only o		1	☐ Yes 2☐ N	
- 0	1 ☐ Yes 2 ☐ No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ N						y at k?	No a	28d. Describe	dence 6 🗆 O	urred			
4 □ H	omicide dete	mined	building	st of my kno	wiedge, deat	h occurred	et the tin	ne, date an	d place, a	City or Too	wn, State) cause(s) and n	nenner as	stated.	
≥ 29b. Signa	ature and little of certification and address of person	m	13.	an	7 200) (Type		c. Licens	e number	2/6	01	29d. Date sign	ned (Month	Day, Year)	
RA	led (Month, Dey, Yes	5 7	5. C	P2R	NON	1.5	7	10 0	- Co	2	120	F		

AH



Physicia /Medic Examin

Funeral Director

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attending Physician: The lew requires that the death certificate be associated within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

			ertificat	e or i	Dealii			Reg. N	lo.		
Decedent's Name (First, Middle, Last	» avid Wallace H	Bellar	d				2. Dete of De Month June	D	ay 199	Year	3. Time of Death 7:30 A.
a Facility Name (If not institution, give	street and number)			4	lb. City, To	wn, or L	ocation of Deat			of Death	1.30 A.
1500 Frederick Re	oad				Cator	svi	lle		Bali	imor	P
. Social Security Number 6. Se	7. Age (In yrs.	last birthday	/ If Under Months		If Under Hours		8. Dete of Bir	th Yes		9 Birth	place (State or Fore
210 12 2013 11	□M 2□F 54	Yrs.	MORRIS	Days	riours	IVIN I.	NOV 10	, I	944	Eng	Tand
Usuel Residence of Decedent On. State 10b. County	10c. Cit	y, Town or L	ocation								10d. Inside City Lim
MD Baltim	ore	Ca	atons	vil.	le						1□ Yes 2□
0e.Street and Number .26 Wyndcrest A	venue		10f. Zip	122	8		0	10g. C	itizen of US	What Cou A	ntry?
1. Merital Status	12. Wes Decedent Ever in U.	S. 13.	Wes Dece	dent of H	ispanic Ori	igin? (Sp	ecify Yes or No Rican, etc.)	)-			can Indien,
1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:		1 Yes, spec	37	Specify:		Hican, etc.)		Specif	ck, White, y: Wh	ite
15. Decedent's Edu (Specify only highest grad		16a. Dece	edent's Usua	al Occup	ation	t of work	ina	16b.	Kind of B	usiness/In	dustry
Elementery/Secondary (0-12)	College (1-4or 5+)		e kind of wo DO NOT u		()	t or work	uny				
	4	F	Embal	mer	40.11		4				ervice
7. Father's Name (First, Middle, Last) Harold Be	llard				18. Mothe		e (First, Middle bel C.			•	
19a. Informant's Neme/Reletionship (T)		10h 14-2	lina Address	/Street	and Atomb						o Codn)
Hillary C. Bel							Route Numb				
Oa. Method of Disposition	20b. P	tace of Disp	osition (Ner	ne of		ven	Dete Ca				MD 212
1 Burial 2 Cremetion 3 F 4 Donation 3 Other (Specify)	Removal from State	emetery, cre st Lav	ematory or o	ther plac		07/	03/99				11e, MD
1. Signature of Foneyal Service Libens	2014 gorchik	M		b Fu	neral	Hon	ne, P.A. Baltimo		MD 1	1220	
23a. Pert1. Enter the disease of complete shock, or heart feilure.	The second secon								ב ענין	1220	Approximete
	ne cause on each line.	<								1	Onset end Death
mmediate Cause (Final disease or condition esulting in death)	Hang	ing								1	
	Due to d	ras a cons	quence of):								
	b									i	
Sequentially list conditions, any, leading to immediate seuse. Enter Underlying	Due to (o	r es a conse	equence of):							I I	
Cause (Disease or injury hat initieted events	C. Due to /o	as a conse	uneuce of/-								
esulting in death) Last	Due to (0	40 S UUI 196	querior (II).								
	d										
art II. Other significant conditions cor	ntributing to death but not rest	ulting In the	underlying c	ause giv	en in Pert I	l.	23b. Did	tobacc	o uae co	ntribute t	o the cause of de
							10	Yes	2 FNO	3 Pro	bably 4 Unkr
							24a. Wes	an eul	opsy	S.	fere autopsy findin vailable prior to empletion of cause
							1758	Ses .	2 🗆 No		death?
5. Wes case referred to medical					26. Place	of Deet	th (Check only				
VVies 5□ IA0	lospital: 1   Inpatient 2	ER/Outpatie	ent 3 DC	Oth Oth	or.				6 <b>K</b> )Ott	ner (Speci	w at scer
7. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M	8c. Injun Work			28d. Describe	how in	ury occu		
3SSuicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif)	ome, ferm, si		, office	ird		28f. Location ( City or To	Street wn, Ste	and Numi	ber or Run	al Route Number
									10 11/1	1 W	
9e. Certifier (Check only one)  1 Certifying Physical Examination	sician: To the best of my knowner: On the basis of examinet and manner stated.	wledge, deel	th occurred nvestigation.	at the tin	ne, date en	d place, th occur	and due to the	ceuse	s) and m	anner as s	stated. to the cause(s)

State Registrar

Dennit J 31. Date filed (Month, Day, Year)

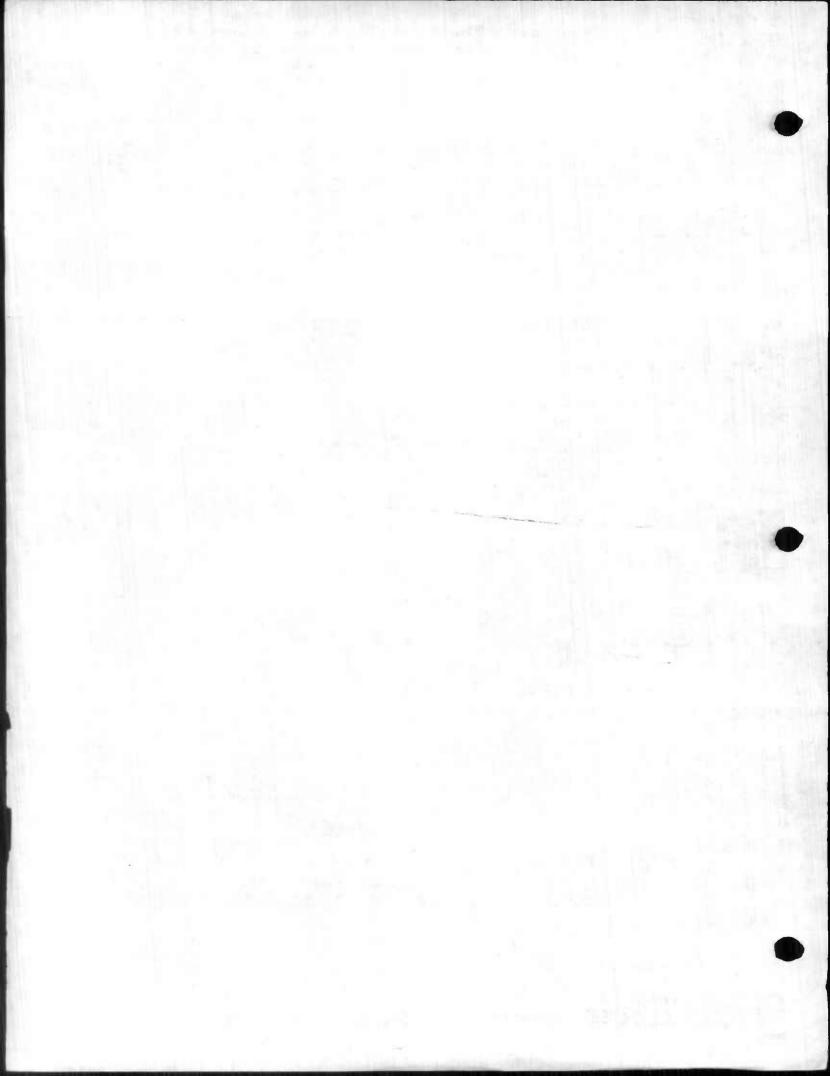
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 2 1999

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DHMH 16 Rev 6/95

111 Penn Street, Baltimore, Maryland 21201

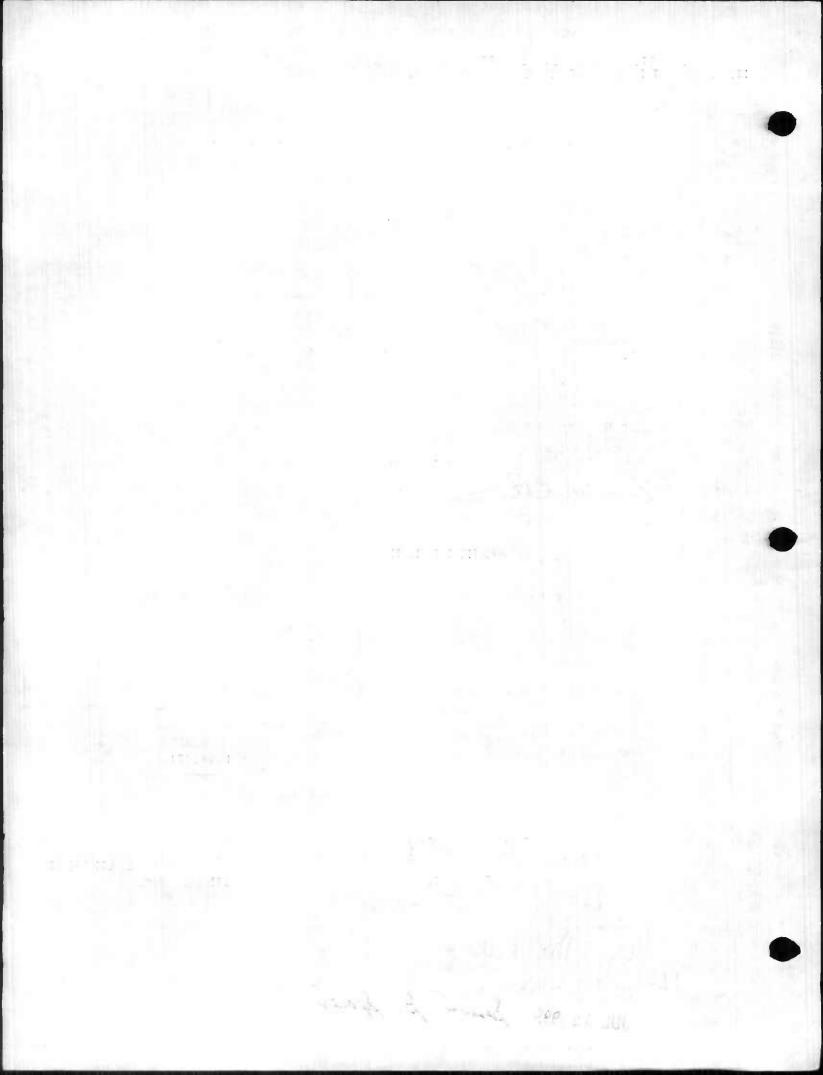


M

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature



#### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yaar 30, JUNE 1999 Jean L. Burgess 9:00 AM 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) 403 Ferndale Avenue Glen Burnie Anne Arundel If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, SEP. 2, If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 🕱 F Months Days 217-22-7724 71 Maryland Usual Residence of Decedent 10a. Stale 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 403 Ferndale Avenue 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-it Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 X No If Yea, Give Year or Dates: 1 Never Married 2 Married 1 Yas 2 No Specify: white Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Sales Retail 11 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surnama) Walter I. McDaniel Hilda M. Shipley 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403 Ferndale Ave., Glen Burnie, Md. 21061 <u>Leonard Burgess - husband</u> 20a. Method of Disposition 20b. Place of Disposition (Name of camatery, crematory or other place) Date 20c. Location - City or Town, Stata 7/03/99 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park Elkridge, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 21. Signature of Funeral Service Licensee 7250 Washington Blvd., Elkridge, Md. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart tailure. List only one cause on each line. Approximate tnterval Between Onset and Deeth Immediate Cause (Finel CAD months disease or condition resulting in death) Due to (or es a consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the undarlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? completion of causa of death? 1 Yes 2U No 1 Yes 2 No 25. Was cese reterred to medicel examiner? 26. Piece of Death (Check only one)

**Physician** /Medical Examiner requires that the death cartificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

r 28a-f show a notified at

Director

Funeral

þ

Completed

Be

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nant of Haelth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f ahow

Baltimore, Maryland 21215-0020

7 is marked other than "natural", or items 23a or traumatic sysnt, me Medical Experient must be a

other t

permit. Page Depertment of Important: If any Injury or = 8

> Examiner Physician/Medical SE b Completed Be Certification: To

physician and s the bunal-transit usa funaral director,

dateched signed t s cartificata has b director, paga 2 s

Division of Vital Records, P.O. Box 68760, or Attending Physician: Aftar this after deat Director: n 24 hours after dag ne Funeral Director nletely filled in by th Hospital To the Hosp within 24 ho To the Fune completely f

State Registrar

29b. Signature and title of certifier

5 Pending

invastigation

6 Could not be determined

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

(Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

rulo, MD Drustus 1

D51018

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

Other: 4☐ Nursing Homa Seridence 6 ☐ Other (Specify)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Bultimore MD Suite 230 Pinta Douglas 3421 Beuson Ave,

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

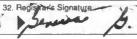
3 Suicide

29a. Certifier

edical

4 Homicide

(Check only one)



1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28a. Date of Injury (Month, Day Year)

28b. Time of

The set of the set of the set of the set

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMENU I	TEM#1 PER PHYN. g773	5-8-99 J.A.	Ce	ertificate of	Death		Reg. No.	= 1000	
Physician	1. Decedent's Name (First, Middle, MARGARET, Margarite E.	Biden				2. Dete of De Month	Dey	Year 999 5:58 AM	
/Medical Examiner	4a Facility Name (If not institution, s Saint Joseph	rive street and number,			4b. City, Town, or	Location of Deal	th 4c. County		
Funeral Director			ge (In yrs. last birthda) 76 Yrs.	/) If Under 1 Year Months Days	If Under 24 Hrs	8. Date of Bi	rth	Birthplace (State or Foreig Country)     Maryland	
	Usuel Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation		F /	,	10d. Inside City Limit	
with the Marylan a or 28a-f show be notified at	Maryland Baltim	ore	Baltimor					1 ☐ Yes 2 🕅 N	
or 28a-fe or 28a-fe be notified	10e. Street and Number	OLE	Daltimol	10f. Zip Code			10g. Citizen of V	Vhat Country?	
h with	1257 Elm Road			21227			U.S.	Δ.	
filed within 72 hours efter death with the Maryland Hygiene, ther than "natural", or flame 23a or 28a-f show ent, the Medical Estimate must be notified at a Completed by Funeral Director	11. Maritai Status  1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 Yes 2 1 If Yes, Give Year or Dates:		. Wes Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☑ No	Hispanic Origin? (S pan, Mexican, Puer	pecify Yes or Noto Rican, etc.)	0- 14. Rac Blac	a - American Indian, k, White, etc. white	
ed within 72 ho ygiene. er than *naturi ft, me Wedcell	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed)  College (1-4or	5+) (Giv	edent's Usual Occu re kind of work done DO NOT use retire	pation during most of wo ad)	rking		d of Business/Industry	
be filed within tall Hygiene. d other than event, the Manager Be Comp	17. Father's Name (First, Middle, La		Sect	etary	18. Mother's Na	me (First, Middle	Medion Sumam	Tariff Till	
Mental H ked off ic ever o Be	George Thomas Bi	den			Annie N	arer			
d 2 should th and Mer 7 is marks traumatic	19a. Informant's Name/Relationship	(Type, Print)	19b. Mai	ling Address (Stree	t and Number or R	ural Route Numb	ber, City or Town,	State, Zip Code)	
Pages 1 an nent of Heal int: If Item 2 iry or other	Kathleen Pinheir  20a. Method of Disposition  1 Burial 2 Cremation 3  4 Connation 5 Other (Spe	□Removal from State	20b. Place of Disp cemetery, cr	ematory or other ple	ace) i	altimore Dete		1.228 City or Town, State	
permit. Departminporta	21. Signature of Funeral Service Lic RONAL  32. Part1. Enter the disease, or conhock, or heart failure. List on	S/ Hallande	irector	Baltimore	omy Board, MD 21	201		nore Street	
Physician /Medical Examiner  Examinet Examinet	Immediate Cause (Final disease or condition resulting in death)	ACUTE a. b.	Due to (or as a cons	equence of):	RCTION				
sate be executed shysician and the bunel-transit dical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Due to (or as a consequence of):								
at the death certificate be exact by the attending physician a stacked for use as the buriet Physician/Medical Ex		d						1	
es that the death igned by the atte be detached for by Physicia	Part II. Other eignificant conditions	contributing to death t	out not resulting in the	underlying cause g	iven in Part i.			atribute to the cause of deet	
aw requir						24a. Wa	s an autopsy ormed?	24b. Were autopsy finding available prior to completion of cause of death?	
yalcien: The last certificate he director, page	25. Was case referred to medical	La mar vari			26. Place of De	ath (Check only	one)		
Physici this cer al direc	examiner?	Hospitei; Inpati	ent 2 ER/Outpation	ent 3 DOA O	hor		idence 6 Oth	er (Specify)	
Attending Physicien: or death. ector: Atter this certifica by the funeral director. iffication: To Be (	27. Manner of Death  1 Natural 5 Panding investiget	28a. Oate of inju (Month, De	ary Year) 28b. Tima Injury	Wo	ry et ork? ] Yes 2 □ No	28d. Describe	how injury occur	red	
tal or Attending Priss after death.  el Director: Atter tiled in by the funers  Certification:	3 Suicide 6 Could not determine	be 28e. Placa of In	jury - At home, farm, s ic. (Specify)				(Street and Numb own, State)	er or Rurel Route Number,	
To the Hospital or at within 24 hours after at To the Funeral Direct completely filled in by Medical Certifi	29a. Certifier Check only one) Certifying I Certifying I Certifying I	Physician: To the best aminer: On the basis o and manner st	f examination and/or i	ath occurred at the t nvestigation, in my	ime, date and plece opinion, death occ	a, and due to the urred at the time	cause(s) and ma , date end plece,	nner as stated. end due to the ceuse(s)	
To th To th comp	29b. Signature and title of certifier	n	Ohoo	29c. Licen D-3	se number 0263			d (Month, Day, Year)	
	30. Name and address of person who		death (item 23a) (Type		TOWSON,	MARYL	NDN 2	1204	
		T	rar's Signature						

66-82-83

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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** Margaret H. Brown June 28. 1999 9:00 A.M. /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 7885 Garden Ct., Apt. 580 Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□ M 2 F 64 Yrs. 214-46-2004 1935 Director Apr. 18, Germany Usual Rasidence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show Maryland Anne Arundel Glen Burnie 1 Yaa 2 XNo Directo 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 7885 Garden Ct., Apt. 580 21060 United States Funeral Barras 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, apecify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 8 1 ☐ Yes 2 No Specify: Specify: White þ 3 Midowed 4 Divorced Year or Dates: Completed Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cook & Waitress Restaurant 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Bernard Hofmann Marie Bayer 19a. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) . or other tra Eddie Owens / Friend 7928 Allard Ct., Apt. 204, Glen Burnie, MD 21061 20b. Place of Disposition (Name of 20a. Mathod of Disposition July 2 20c. Location - City or Town, State emetery, cremetory or other place) 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State Baltimore Nat. Cem. 1999 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service bicensee 21. Signatur 22, Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Cause (Finel disaase or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown ğ 8 Completed 24b. Were autopsy findings available prior to 24e. Was en eutopsy performed? completion of cause of death? page 2 1 Yes 2 X No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Hospital: Other: 4 ☐ Nursing Homa 5 🖺 Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 쿭 27. Menner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? Affar 1 Natural 5 Pending 1 TYes 2 No Investigation 2 Accident hours after deal neral Director: 3 Suicide 6 Could not be 28t. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide A 24 han 29e. Certifier Medical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner\_etated. To the T 29b. Siggeture)and title of certifie 29d. Date signed (Month, Day, Year) June 30, 1999

State Registrar

with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0020

Box 68760

P.O.

Records,

Division of Vital

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Jorge M. Ramirez, 31 Date filed (Month Day, Year) 1999 JUL

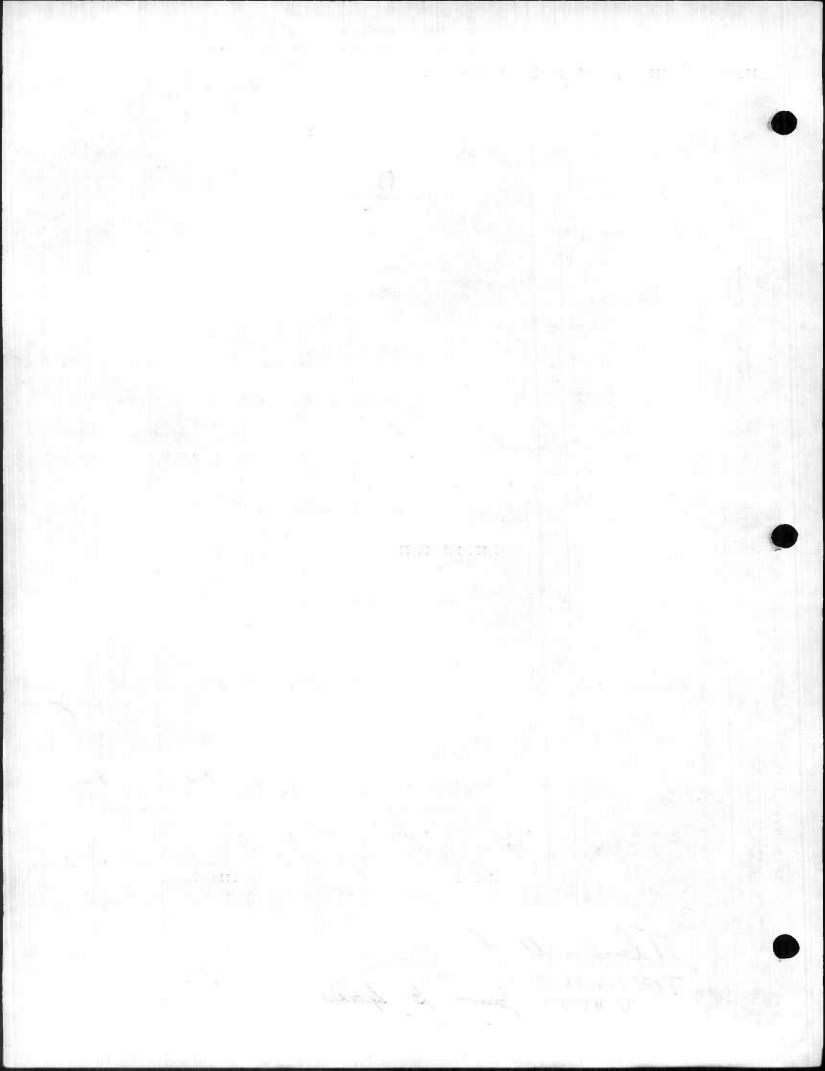
and address of person who completed cause of death (from 23a) (Type, Print)

7845 Oakwood Rd., Suite 106, Glen Burnie, MD 21061 M.D., 32. Registrar's Signature



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	I, 27, 28A-F lent's Name (First, Mic	ddia, Last)							Death	2. Dete of Month		Day	Year	Time of Death	
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	ty Neme (If not institut 20 GWYNNDA			imber)				ľ	tb. City, Town, o WOODLAW		eath	4c. County BALT	Of Death		
5. Social	Security Number	6. Sex		7. Age	(In yrs. le	ast birthday)		er 1 Year s Days	If Under 24 Hr Hours Mir		Birth Day Yes	nr)	9. Birthplace	(State or Foreign	
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Mary	land Balt	imore				Wo	odla	เพา					1	☐ Yes 2 No	
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	Monica Ba	ldwir	1					-	e Avenue	Balt:	_	nore, MD 21207			
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40	Donetion 5 ☐ Other	(Specify)			Woo	odlawn				July 3		W	Voodlaw	n, MD	
21. Sign	Stephe	an Y	n 9	en	Kir	L	orir	g Bye	ss of Facility ers Fune rty Road					133	
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Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									1						
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Part II. O	ther significant condi	tions contr	ibuting to d	eath but	not resu	ting In the un	derlying	cause giv	en in Pert I.	23b. (	Old tobac	co use cor	ntribute to the	cause of death?	
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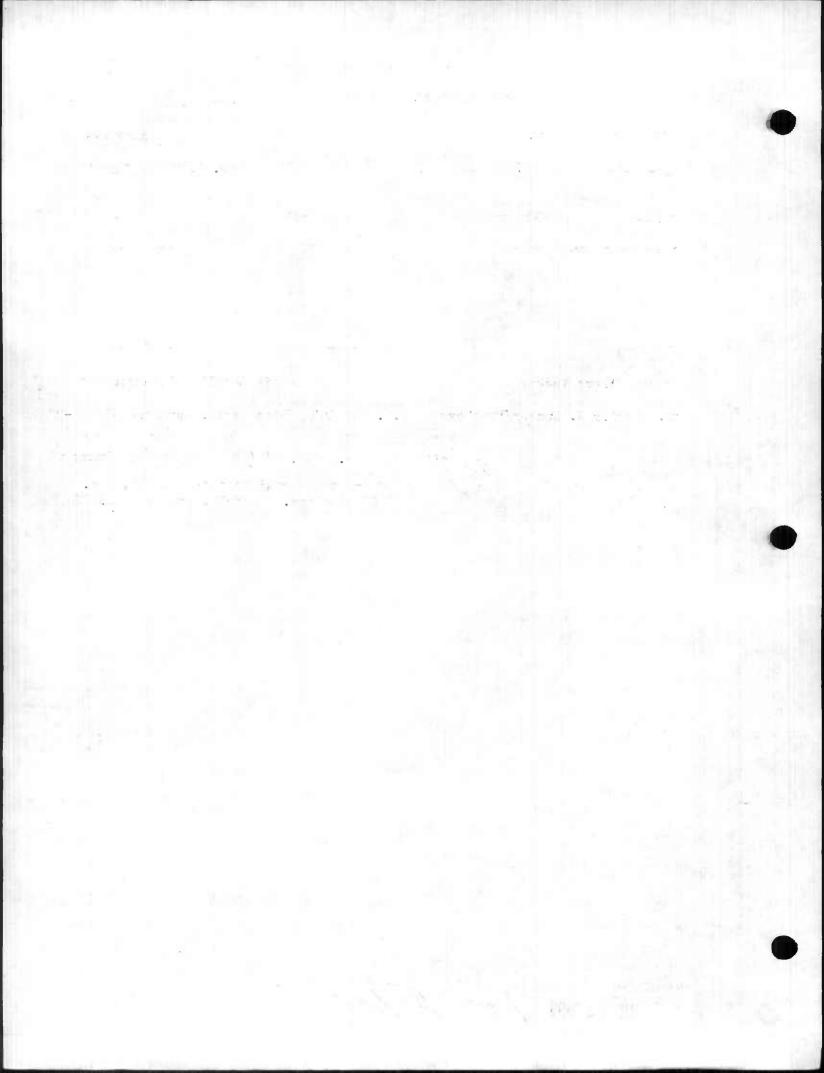
State of Maryland / Department of Health and Mental Hygiene 9 2 1 0 0

Certificate of Death Reg. No.

Physician				0011	ificate	OI L	Jeani			Reg. No.				
ritysiciali	1. Decedent's Name (First, Middle		/ Elizabe	th B	urphan	n			2. Date of De Month	Day	Year	3. Time of Death		
/Medical				CII D	ar mian		0: -		June 3	0, 1999		8:05PM		
Examiner	4e Facility Name (If not institution 8218 Bear Cree		nber)				Dunda	alk	ocation of Deat			re		
Funeral Director	5. Social Security Number 212–26–8974	6. Sex 1□ M <b>X</b> □ F	7. Age (In yrs. last 69	birthday) Yrs.	If Under 1 Y Months D	ear ays	If Under 2 Hours	Min.	8. Dete of Bir (Month, De Aug • 4	th Year) 1929	9. Birthp Cour Mar	lace (State or Foreig try) y Land		
	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Loc	ation						I	Od Ineida City Limit		
23e or 25e-f show ust be notified at rail Director	Maryland	Baltimor		own or coo			dalk					1 ☐ Yes 20XN		
23s or 2 unit be n	10e. Street and Number 8218 Bear Cree	k Drive			10f. Zip Co	de	21222	2		United States				
r, or Herra Complex in	11. Maritel Status  1 Never Married 2 Men 3 Widowed 4 Divorced	Armed Fo	21 No		as Decedent Yes, specify		spanic Origin, Mexican, Specify:	nin? (Spi , Puerto	ecify Yes or No Rican, etc.)	Sle	etc.			
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Mental H arked off afte ever	17. Father's Neme (First, Middle, Norman Albert									Maiden Suman e Zimmei				
oath and n 27 is ma er traum														
ant of Heart II	19a. Informant's Neme/Relationship (Type, Print)  Mr. Charles J. Tucker/Brother  19b. Meiling Address (Street and Number or Rural Route Number, City or Town, St. P.O. Box 264 White Marsh, Maryland  20a. Method of Disposition  12b. Meiling Address (Street and Number or Rural Route Number, City or Town, St. P.O. Box 264 White Marsh, Maryland  20b. Plece of Disposition (Name of cemetery, cremetory or other place)													
Departme Importan any injur ance.	21. Signature of Exercise Licenses 22. Name end Address of Facility													
hysician /Medical xaminer	23a. Pert1. Enter the disease, or shock, or heart failure. List Immediate Ceuse (Final disease or condition resulting in death)	only one cause on	ach line.	n Cer	r the mode of									
ding physician and se as the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b	Due to (or es								t I I I			
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Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death В. BROW N Month DORIS 15:12 1999 JUNE 30 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GOOD SAMARITAN HOSPITAL If Under 1 Yeer if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1924 5. Sociei Security Number 9. Birthplace (State or Foreign Country)
Balto, MD 7. Age (In yrs. lest birthday) Months Days 1□ M 2□ F 74 Yrs 218 12 6642 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 No Catonsville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Summitt Hill Ct. Apt 1A 21228 USA 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-It Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health Care Registered Nurse 12th 4 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anna Marie Harold E. Morgan 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straet and Number or Rural Route Number, City or Town, State, Zip Code) 3622 Windfall Terrace. Ellicott City, MD21042 Joel Brown/ Son 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Balto/Wash Crematory7/2/99 Laurel, 21. Signature of Funeral Service Licenses 22. Name and Address ot Facility Sterling-Ashton-Schwab Funeral Home Inc. 736 Edmondson Ave. Catonsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each lina. Approximata Intarval Betw Immediate Causa (Final CARDIAC ARREST disease or condition resulting in death) ISCHEMIC CARDIOMYOPATH) Due to (or as a consequenca ot): Dua to (or as a consequenca of): Part ti. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown 24b. Ware autopsy tindings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Yas 2 No 1 ☐ Yes 2 No 28. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day Year) 27. Manner of Daath 28b. Tima ot 28c. Injury at Work? 28d. Describe how Injury occurred 1 Yes 2 No

**Physician** /Medical Examiner

pue

thet the death certificate be executed

Box 68760,

P.O.

Records,

Division of Vital

permit. Pages 1 end 2: Department of Health et Important: if Item 27 is any injury or other traugung.

**Physician** 

/Medical

**Examiner** 

Director

Funeral

þ

Completed

MD

**Funeral** 

Director

tem 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Manical Examinar must be notified at

Pages 1 end 2 should be filed within 72 hours efter onent of Health end Mentel Hygiene. Int: If Item 27 is marked other than "natural", or ite

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last

by

physician Physician/Medical the signed by the e Completed peen ate hes director. Be 2 this • Hospital or Attending PI n 24 hours efter death. • Funeral Director: After the letely filled in by the funeral Certification:

COPD

25. Was casa raferred to madical examiner? 1 ☐ Yes 2 X No

> 5 Pending invastigation 2 Accident 6 Could not be datarmined 3 Suicide 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie

28e. Place of Injury - At home, tarm, street, factory, offica building, etc. (Specify)

29c. License number 12 555 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print)

ALTAHA. GOOD SAHARITAN HOSPITAL, 5601 LOCH RAVEN BOULEVARD, BALTIMORE 31. Data tilad (Month, Day, Yaar)

State Registrar

Medical

29a. Cartifiar



B. Sporter

DHMH 16 Rev 6/95

To the Hospital o within 24 hours of To the Funeral Di completely filled in

Linderen a ngwa

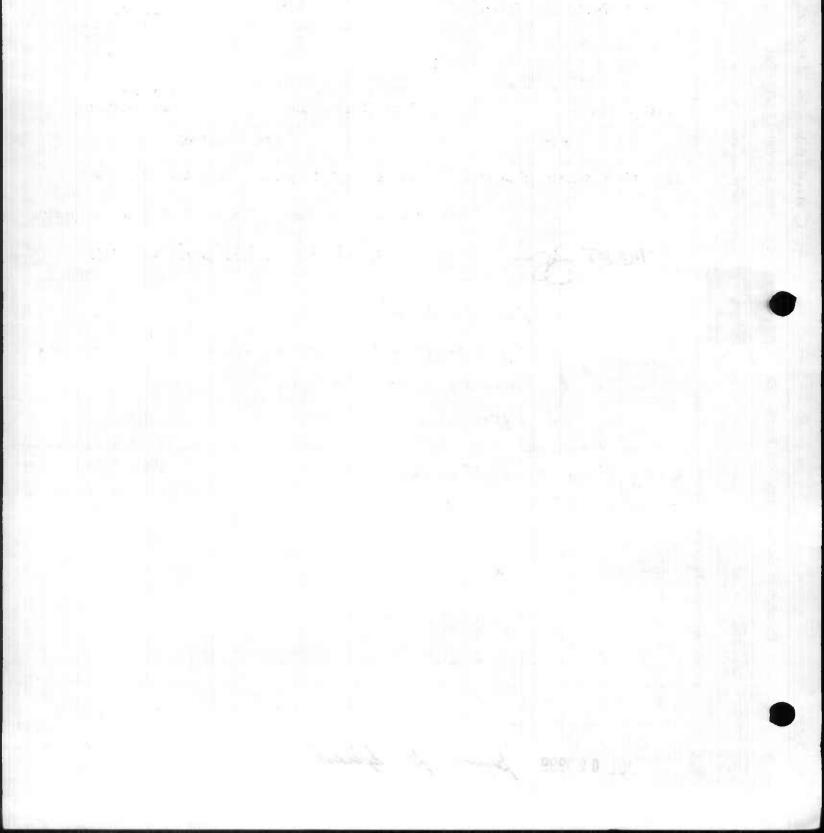
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DR. Chung

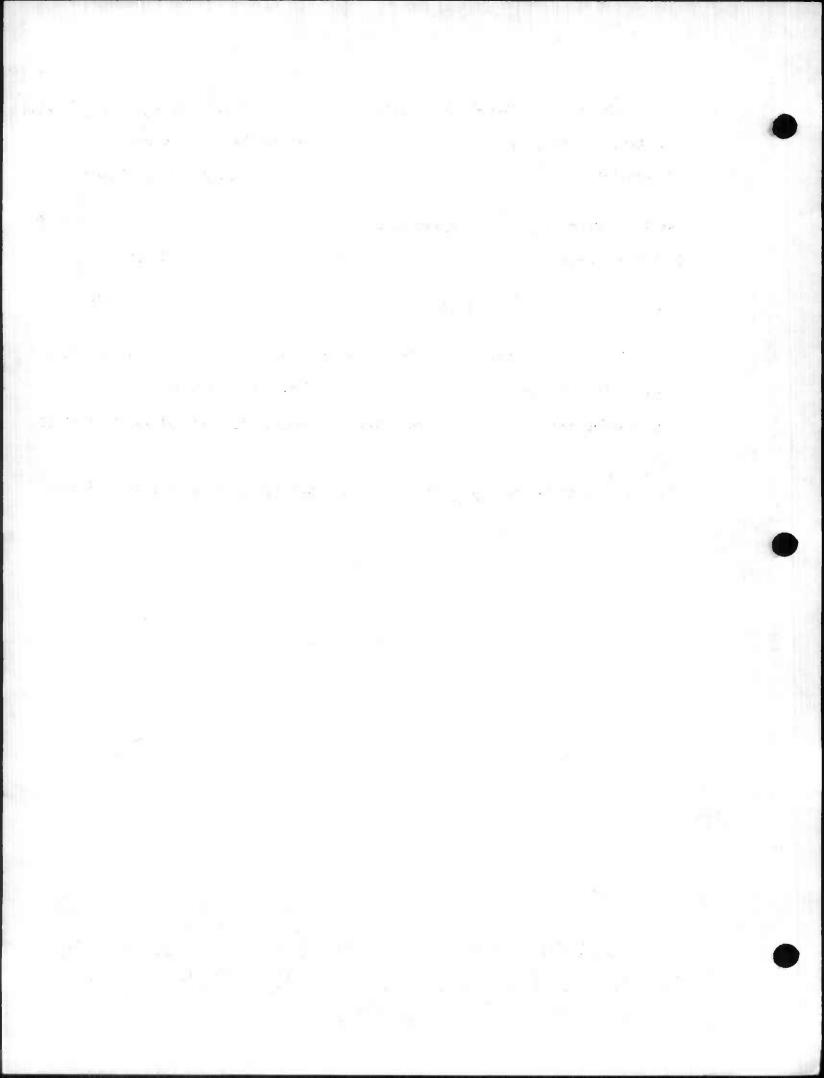
SPURE DR. BAITIMORE.

State Registrar



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Certificate of Maryland / Department of	of Death	Reg. No.			
Physi /Med	dical	1. Decedent's Name (First, Middle, Last) 627ald Edward Cole	2. Dete of C Month	20 1999 1:15 AM			
Exam	iner	4a. Facility Name (If not Institution, giva street and number)	4b. City, Town, or Location of Dec				
		Fairhaven Nursing Home	Sykesville	Carroll			
Funera Directo		5. Social Security Number  217-36-2562  Usuel Residence of Decedant  6. Sax 1 M 2 F 7. Aga (In yrs. last birthday) 81 Yrs.  Months Da		Sirth Sey, Year)  9, 1917  9. Birthplaca (Stete or Foraign Country)  Kansas			
ahow	5	10a. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limits 1 ☐ Yes 2 🛣 No			
he N	Director	Maryland Carroll Sykesville					
Vith Vith				10g. Citizan of What Country?			
23	Fra	7200 3rd Avenue 2178		U.S.A.			
within 72 hours efter death with the Maryland ene. than "natural", or items 23a or 28a-f ahow he Modical Examinal must be notified at	by Funeral	1 Never Merried 2 Merried 1 X Yas 2 No If Yes, Give Year or Detes: 1941-43	of Hispanic Origin? (Specify Yas or Nouben, Mexican, Puerto Rican, atc.)  No Specify:	14. Race - Amarican Indlen, Bleck, White, etc.  Specify: White			
72 ho	P P	15. Decedent's Education 16e. Decadent's Usuel Oc	cupetion	16b. Kind of Businass/Industry			
	Completed	(Specify only highest grade completed)  Elementery/Secondery (0-12)  12  (Give kind of work do life. DO NOT use re		College Education			
be filed tal Hygid d other event, to	BeC	17. Father's Name (First, Middle, Last)	18. Mothar's Nema (First, Midd	a (First, Middla, Malden Surneme)			
2500	0	Charles Edward Cole	Elma Jane Mull	igan			
	-	19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Str.	eet end Number or Rural Route Num	ber, City or Town, State, Zip Code)			
rtra		Carl Hall/nephew 2470 Liberty	v Avenue, Missour	i Valley, Iowa 51555			
OF IT		20e. Method of Disposition  1 Burlel 2 Cremetion 3 Removal from State  4 Donetion 5 Other (Specify)	Deta	20c. Location - City or Town, Stata			
pemit. Pege Department of Important: If eny injury or	A STATE OF THE STA		atomy Board, 655	W. Baltimore Street			
_		23e. Part1. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of shock, or heart tellure. List only one cause on each line.		errest, Approximete			
eath certificate be executed xx a strending physician and if or use as the bunel-transit a point.	edical Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth)  Bue to (or es e consequence ot):  Due to (or es e consequence ot):  Due to (or es e consequence ot):  Due to (or es e consequence ot):  Cuse. Enter Underlying Cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest  Dua to (or as a consequence of):  Dua to (or as a consequence of):	( Cing	(w) glas			
death cert e attendin ed for use	Clar						
that the de- ed by the a deteched t	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Pert I. 23b. Di	d tobacco use contribute to the cause of death			
thet dete			1[	☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknow			
w requires s been sign 2 should be	Completed by			24b. Were eutopsy findings available prior to completion of causa of deeth?			
0 5 0	O		10	Yes 2 No 1 Yes 2 No			
ician: The certificate rector, pag	Be (	25. Wes case reterred to medical	26. Place of Deeth (Check only	( one)			
5 00	To E	examinar?  1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Homa 5 Re	sidence 6 Othar (Specify)			
Attending Physic death.  ector: After this by the funeral di		1 ☑Neturel 5 ☐ Pending (Month, Dey Year) Injury		e how injury occurred			
s efter de ni Olrecto ed in by th	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, offi building, etc. (Specify)	ce 28t. Location City or T	(Street end Number or Rural Route Number, own, Stete)			
To the Hospital or Attending Phywithin 24 hours efter death.  To the Funeral Director: After this completely filled in by the funeral	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deeth occurred at the control of the basis of examination and/or investigation, in men men and menner stated.	e time, dete end plece, end due to th ny opinion, deeth occurred et the time	e cause(s) end menner as stated. e, dete and pleca, end due to the cause(s)			
To the to the community	Σ	29b. Signeture end title ot cepting.	ensa number	29d. Date signed (Month, Dey, Year)			
		) /(W/h)	33184	June 29, 1999			
		30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)	to Dive Ri	3 Ketenn MD			
S Regis	tate trar	31. Dete tiled (Month, Dey, Yeer)  JUL 0 2 1999  32. Registrer's Signeture  4. Soci	61				



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

•				State of Mary	/land	Certifica			Mental H	Reg. No.	3 21013			
4	Physicia: /Medica	n	1. Decedent's Neme (First, Middle, La HAYWARD	st)			AR	TER	2. Dete of D Month	Day	Year 10:50			
	Examine	er		topkinis l	-		or 1 Yea	4b. City, Town, or Ba (+	'more	N/A	A			
L	Funeral Director		5. Social Security Number 6. S 215-28-4483 Usual Residence of Decedent	7. Age (III		Yrs. If Under			. (Month, E		Birthplece (State or Foreign Country)     MARYLAND			
	with the Marylan s or 28e-f show be notified at	Director	10a. Stete 10b. County MARYLAND	n/a	c. City, T	Fown or Location BALTI	MOF	RE		10d. Inside City Lim 1 □Xes 2 □				
		2	10e. Street and Number  1703 N. REGIS 11. Meritel Stetus	STER ST.	r in U,S.			21213 Hispanic Origin? (San, Mexican, Puer	Specify Yes or N	U.S.A. o- 14. Race - American Indian,				
0050	or of	D.	1 ☐ Never Merried 2 ☑ Merried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Yeer or Detes:		1 Yes			no Hican, etc.)	Specify	KFRO-AMERICAL			
21215-0020	within 72 h one. then "nets he Medica	Completed	15. Decedent's Ed (Specify only highest grade) Elementery/Secondery (0-12) 10TH	College (1-4or 5+)		6a. Decedent's Usu (Give kind of w life. DO NOT	ork don use retir	e during most of wa	orking	BALTO.CITY SC				
Maryland 2	2000	o se c	17. Fether's Neme (First, Middle, Last, JAMES CARTER	N/A		Jenoon L	ne)							
, Mary	and 2 shows and No. 27 is men at Traumal		19e. Informent's Neme/Reletionship ( LYNETTE CARTE	R / WIFE	]	L620 DUR	HAM			nber, City or Town, Stete, Zip Code)  1D . 21213				
Baltimore	Pages 1 ment of Hs ant: If Iten lary or oth		20a. Method of Disposition  X☐ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif	Removel from State	20b. Plec cem MT.	e of Disposition (Ne etery, crematory or ZION C	other pi		LY 6,		City or Town, State			
Ball	Depart Import any in		21. Signature of Funeral Service Licer	Scruge	of to	CALV 1412	IN E.	B. SCRU PRESTO	N STRE	ET BAI				
5	Physician /Medical		23a. Pert1. Enter the disease, or com shock, or heert feilure. List only Immediate Causa (Final	one cause on each line.				ying, such es cardie	c or respiratory	arrest,	Approximate Interval Between Onset end Death			
	Examiner		disease or condition resulting in deeth)	. 1	e to (or as	BLEED s a consequence of					30 YEARS			
o,	cate be executed physician and s the burial-transit		Sequentially list conditions, if any, leeding to immediate cause. Enter Undertying Cause (Disease or injury	U.		S a consequence of	):				JO YEAR			
x 68760,			Cause (Disease or injury thet initiated events resulting in death) Last	C. Due	to (or es	s e consequence of)	:							
P.O. Box	that the death certificated by the attending detached for use as	rnysicianym	Part II. Other significant conditions of	ontributing to death but no	ot resultir	ng in the underlying	cause ç	given in Pert I.		d tobacco use co	ntribute to the cause of death			
Records, F	th se d		UROSEPSIS						24a. We	s en autopsy formed?	24b. Were autopsy findings available prior to completion of cause			
al Rec	The lay	Completed							10	Yes 2018 No	of death? 1 ☐ Yes 2 ☒ No			
Vital	certificate irector, pa		25. Wes case referred to medical axaminer?	Hospitel:				Whor:	eth (Check only					
of	hys his	-  -	1 Yes 2 No  27. Menner of Death 1 Noturel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Ye	28		28c. Inj	4 LI Nursing	-	sidence 6 Oth a how injury occur				
Division	2446	Certifica	3 Suicide 6 Could not be determined	28e. Plece of Injury - building, etc. (S	At home	a, ferm, street, fecto	ry, office	0		(Street and Numb own, Stete)	per or Rural Route Number,			
	Hospi 4 hou Funer taly fill	8200	29e. Certifier 1 ☐ Certifying Ph (Check only one) 1 ☐ Medical Exam	yalcian: To the best of miner: On the basis of exa end menner steted.	minetion	dge, deeth occurred and/or investigetion	d et the n, in my	time, dete and place opinion, deeth occ	e, and due to th urred et the time	e cause(s) and me o, date and plece,	ennar as stated. and due to the cause(s)			
	within 2 To the comple		29b. Signeture end title of certifier  Raulel M. Cou	mul. M.	D.			S = OOO			30, 1999			

State Registrar

31. Dete filed (Month, Day, Year) 2 1999 JUL

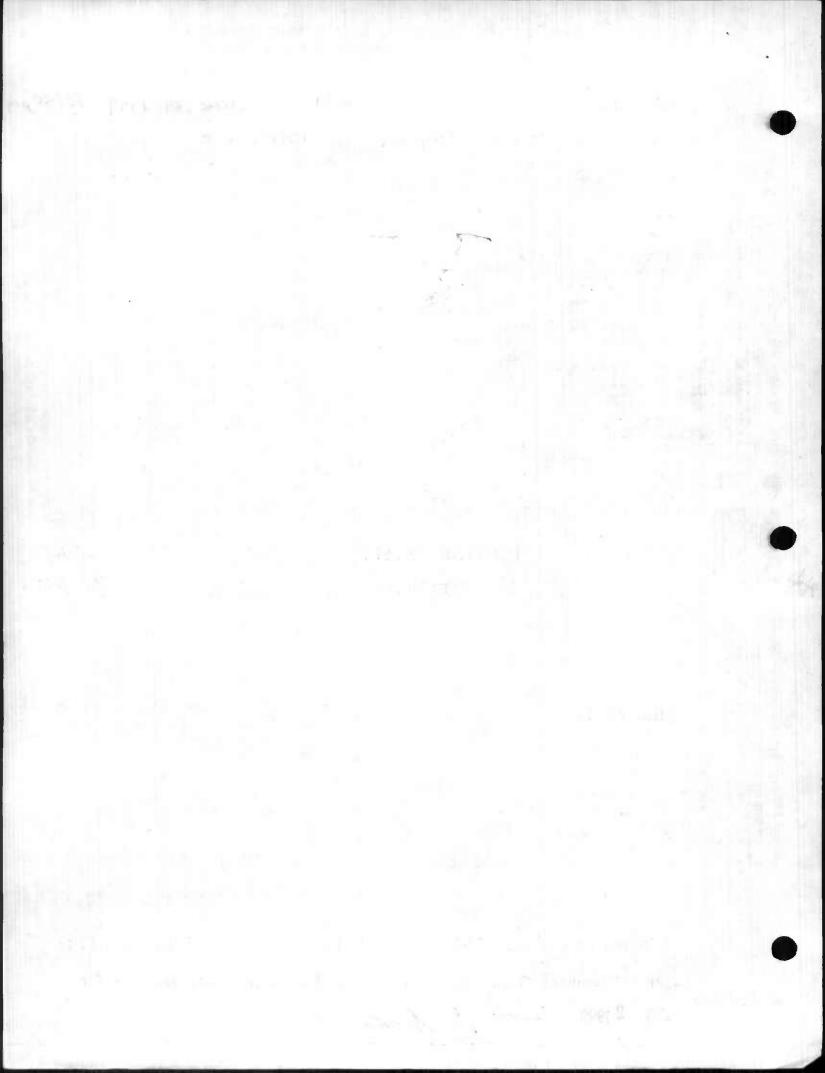
32. Registrer's Signeture

RACHEL M'CORMICK, JOHNS HOPKINS HOSPITAL, BALTIMORE, MARYLAND

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

DHMH 16 Rav 6/95

21287



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death Amended Item#8 perFH G773 7/2/99 EW 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 7:15 am George Edward Ciscle 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Mariner Health Care of BelAir BelAir Harford If Under 1 Year 5. Social Security Number If Undar 24 Hrs. 7. Age (In yrs. last birthday) 8. Data of Birth 3-17-11 9. Birthplace (State or Foreign (Month, Dey, Year) 100 M 2□ F Months Days Hours Yrs. 212-01-5118 85 April 16,1914 Baltimore City,MD. Usual Residence of Decedent 10s State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 X No Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1910 High Point Road 21050 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forcas? 1 (X) Yas 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Stafus Biack, White, etc. 1 □ Naver Married 2 □ Married 1 ☐ Yes 2 ☐XNo Specify: Specify: 3 X Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) 9 yrs. n/a Foreman Overbrook Egg Nog Co. 18. Mother's Name (First, Middle, Maidan Sumame) 17. Fathar's Name (First, Middle, Last) William Thomas Ciscle Lillian Oches 19b. Malling Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a, informant's Name/Relationship (Type, Print) Mrs.Ruth Argentino (Daughter) 1910 High Point Road Forest Hill, Maryland 21050 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Cem, 7/1/99 Baltimore, Maryland 22. Nama and Addrass of Facility 21. Signature of Funeral Service Lioptise E. F. Lassahn Funeral Home 23a. Part 1. Enfer the disease, or a mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Approximate Approximete Interval Between Onsat and Death acute Myorandial Infunction immediate Cause (Final SICONIC disaasa or condition rasulting in daath) Sequantially list conditions, if any, laading to immadiate ceuse. Entar Undarlying Causa (Disaase or injury that initiated events rasulting in daath) Last Due to (or as a consequence of): Due fo (or as a consaquanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 2 XNO 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to 24a. Was an autopsy completion of causa of death? 2KNO 1 ☐ Yes 2 ☐ No 25. Was case refarred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury af Work? 28d. Describe how injury occurred 28b. Time of 1 Naturai 2 Accidant 5 Pending investigation 1 Yas 2 No 6 Could not be datarmined 3 Suicide 28f. Location (Straet and Number or Rural Route Number, City or Town, Steta) 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicide Text Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

/Medical Examiner physician end s the burial-transit law requires that the death certificate be executed signed by t peed ils certificata hes director, page 2 Hospital or Attending Physicien: this After after death Director: / d in by the f To the Hospital or within 24 hours aft To the Funerel Di completaly filled in

**Physician** 

/Medical

Examiner

Director

Funeral

by

**Funeral** 

Director

d other than "naturel", or items 23s or 28s-f show event, the Medical Examiner must be notified at

e filed within 72 hours effer el Hygiene.

Pages 1 end 2 should be filk ment of Health end Mentel Hyant: If item 27 is marked oth ury or other traumatic event

permit. Page Department of Important: If any injury or

**Physician** 

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

Baltimore, Maryland 21215-0020

the Marylend

death with

State Registrar

31. Data filad (Month, Dey, Year

29b. Signature and title of certifier

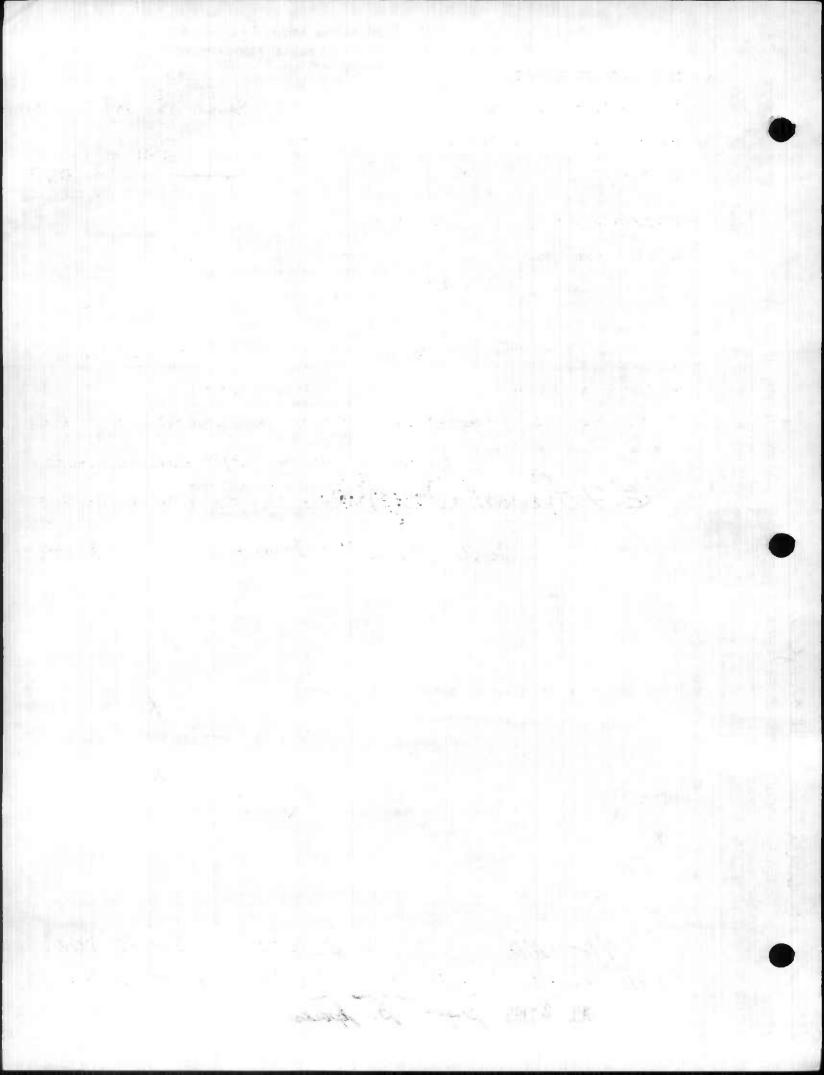
29c. Licansa number 034652 29d. Dafa signed (Month, Dev. Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North

Bil Air Manyland

Avenue

32. Registrate Signature.



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DOWLING TUNE MAR) 22:36 30 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death GOOD SAMARITAN HOSPITAL BALTIMORE N/A 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Hours Days 10 M 2 KF Months 212057936 95 Yrs. Haryland Usual Residence of Decedent 10h Counts 10c. City, Town or Location 10d. Inside City Limits tXYes 2 □ No Baltimore Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 USA 6225 York Road 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 27 No Specify: Specify: White X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Powers John Getz 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1015 Marleigh Circle Towson, Maryland 21204 Mary Alice Harvey Niece 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition
1XXBurial 2 □ Cremation 3 □ Removel from Stete 20c. Location - City or Town, State Date Donation 5 Other (Specify) 7/3/99 New Cathedral Cemetery Baltimore Maryland neture of Funeral Service Licensee 22\_Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 6500 York Road Baltimore, Maryland 21212 nus 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, abook, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death Immediate Cause (Final CARDIAC ARRES disease or condition resulting in death) CARDIOMYOPATH Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed?

**Physician** /Medical Examiner

signed by I

this certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

þ

Completed

Be

70

Certification:

edical

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiere. Important: If Item 27 is marked other than any Injury or other traumatic event. Ibs Ma

**Physician** 

/Medical

Examiner

Directo

Funeral

py

Completed

Be 2 10a State

Funeral

Director

r than "natural", or hams 23a or 28a-f the Medical Examiner must be notifie

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records.

Division of Vital

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and physician s the burial Physician/Medical

1 Yes 2 No 26. Place of Death (Check only one)

1 ☐ Yes 2 No

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death

5 Pending investigation

6 Could not be

28a. Dete of Injury (Month, Day Year)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Tima of

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

29a, Certifier

1 Natural

2 Accident 3 Suicide

4 Homicide

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 12 555 29d. Date signed (Month, Day, Year) 06,30,1999

28f. Location (Street and Number or Rural Route Number, City or Town, State)

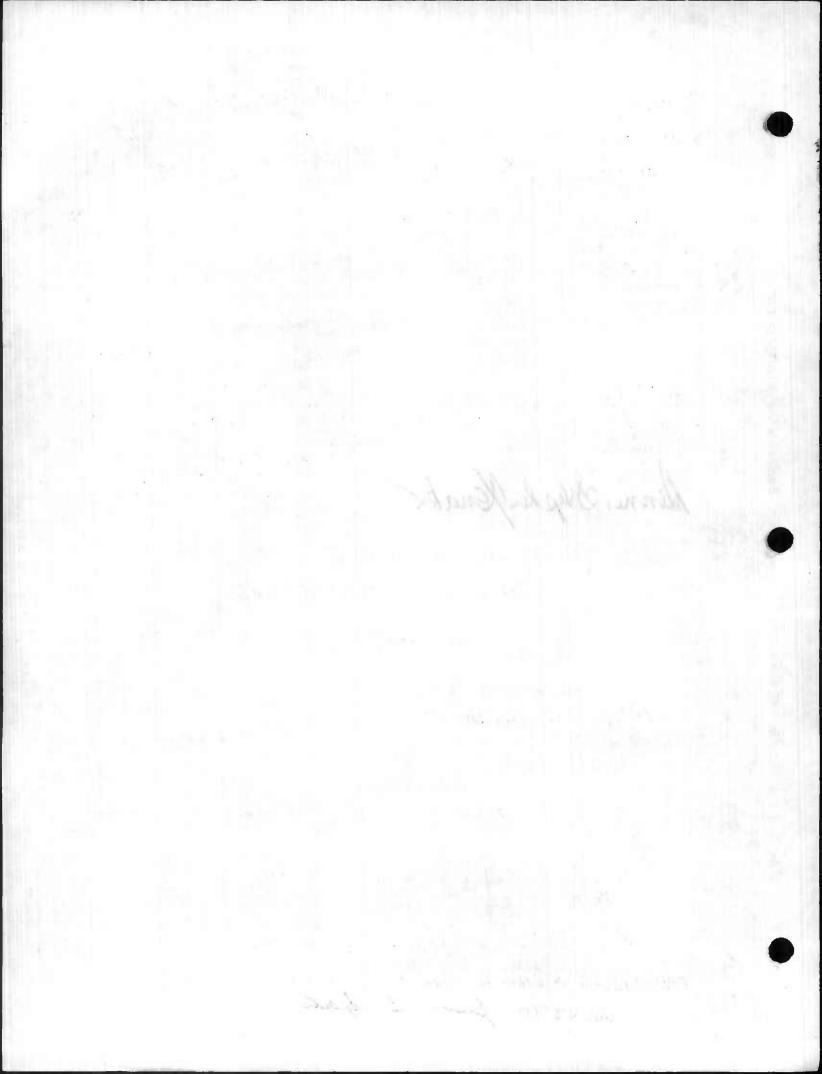
30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print)

RAMIN ALTAHA, GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BOWEVARD, BALTIMORE 31. Date filed (Month, Day, Year)

State Registrar

JUL 0 2 1999

32. Registrar's Signature



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month Year 30, Frederick Timothy Deuber 1999 June 11:49PM 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1 Hunting Creek Court Baltimore Catonsville 5. Social Security Number if Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 29, 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 11☑ M 2□ F Months Days Hours 1936 216-30-6718 63 Yrs. Usual Residence of Decedent 10e State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1 Hunting Creek Court 21228 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 (₹Yes 2 □ No If Yes, Give Yeer or Dates: 196 Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 □ Widowed 4 □ Divorced 1963 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Branch Manager TBM 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel R. Deuber Lois I. Foster 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Hunting Creek Court, Catonsville, MD 20b. Place of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City of Catonsville (Name of Catonsville) 21228 Jeanette Deuber (Wife) 20a. Method of Disposition th☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Park 7/6/99 Sykesville, Maryland 21. Signature of Ednard Service Licensee 22. Name and Address of Fecility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death the Hanna immediate Ceuse (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to Immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of) Due to (or as a consequence of) 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings eveileble prior to 24a. Was en eutopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 20 No 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 5 Aesidence 6 Other (Specify) 28e. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 5 Pending Investigation 1 ☐ Yes 2 No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, attanding physician cartificate or Attending Physician: Aftar this death. within 24 hours after death To the Funeral Director: completely filled in by the 9

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Directo

Funeral

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Completed

Be

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinat must be notified at

permit. Pagas 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 2 any injury or other treumatic event, the Wedicel Examiner must be 2008.

**Physician** 

/Medical

Baltimore, Maryland 21215-0020

the Maryland

Physician/Medical Part II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. signed by t à Completed 25. Was cese referred to medical Be 2 1 Yes 27. Manne of Deeth Certification: Netural 2 Accident 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, end due to the ceuse(s) and menner stated. edicai 29a. Certifier (Check only one)

29b. Signeture end title of certifier

31. Date filed (Month, Day, Year)

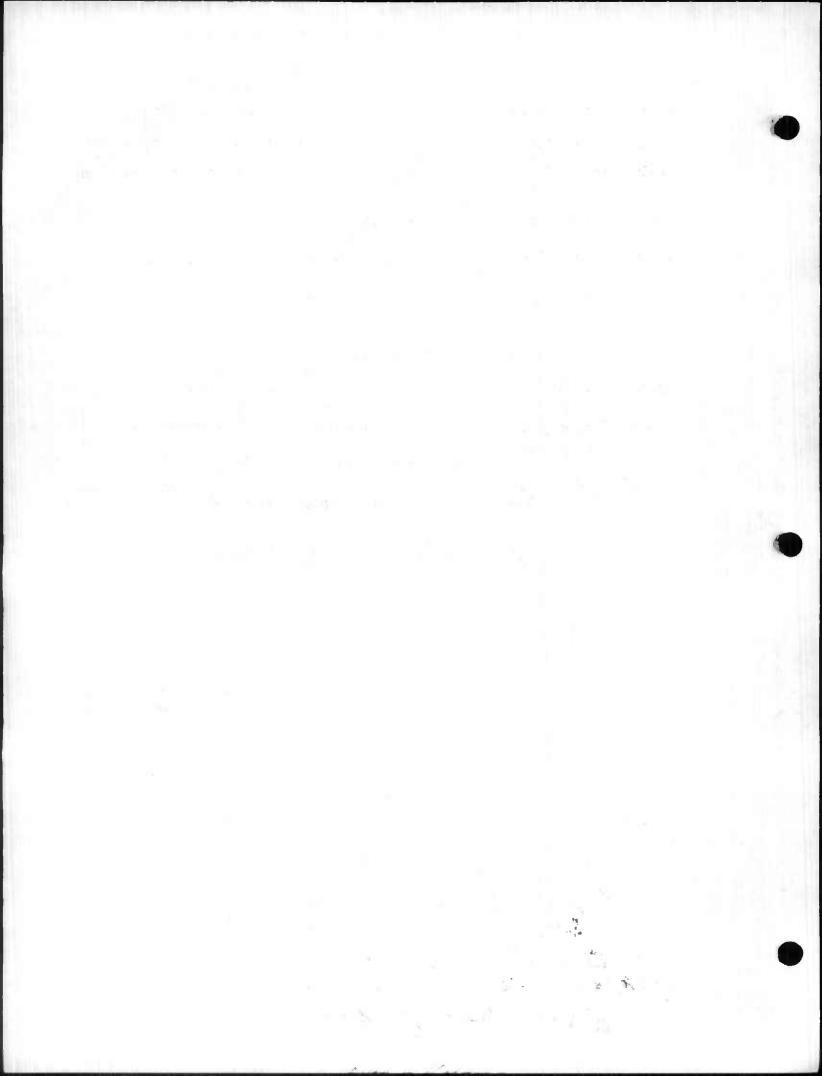
29c. License number 29d. Date signed, (Month, Day, Year)

30. Name end, ddress of person who completed cause of death (Item 23a) (Type, Print) LE HNDRO ME

HOT Frederick Rd Baltimore MD21221

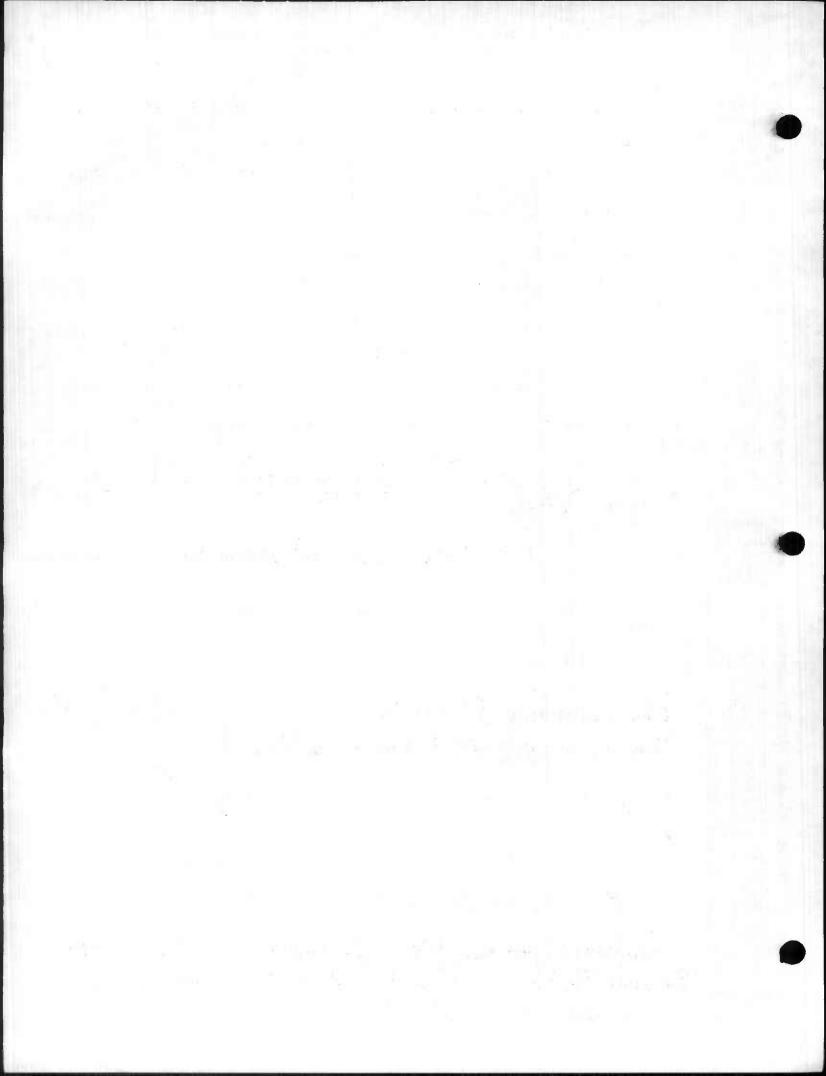
State Registrar

32. Registrer's Signature



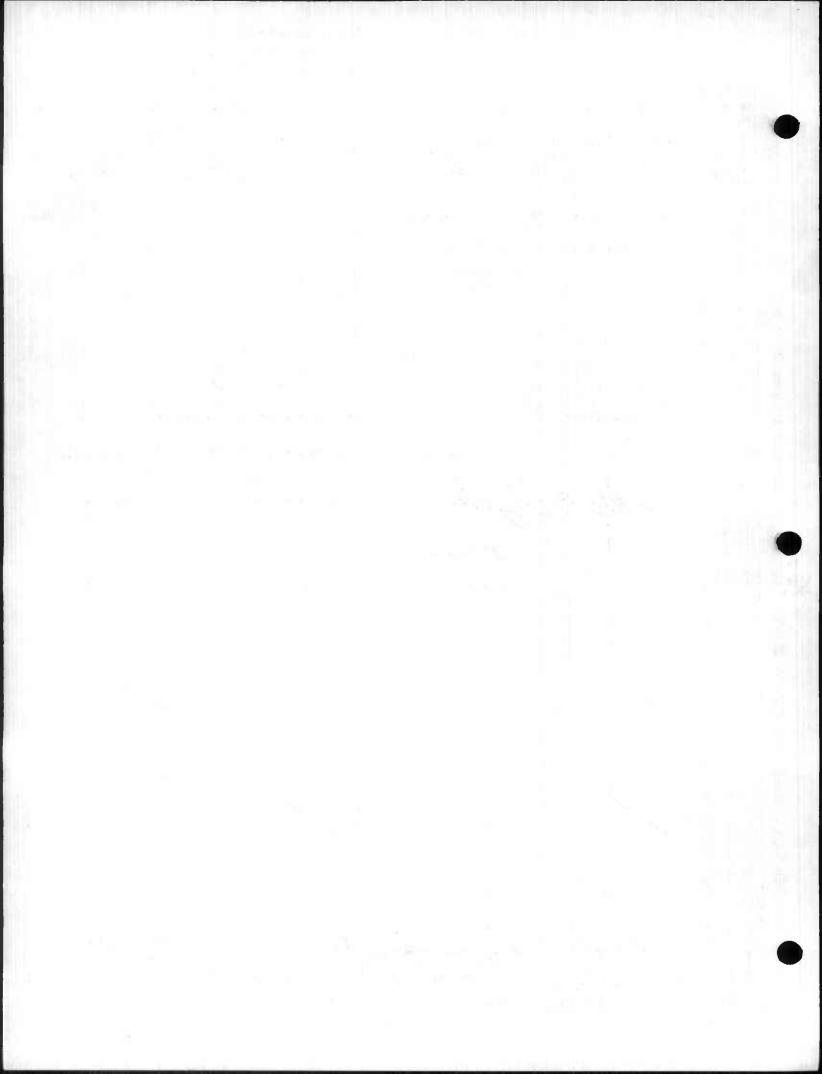
# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q 2 1 0 1 7

D		1. Decedent's Name (First, Middle, Last	")			3	2. Date of Deat		V	3. Time of Deeth	
Physici /Medio		Robert	Orville Eva	ans			June .	$30^{Day}, 19$	99	7:50 A	
Examin		4a. Fecility Name (If not institution, give	street and number)			4b. City, Town, or Loca		4c. County			
		4503 Leeds Ave	enue			Arbutus		Ва	1tim	ore	
Funeral Director			x		Under 1 Year onths Deys	Hours Min.	B. Date of Birth (Month, Day, EC 24,	1915	9. Birthpl Count Mary	ace (State or Foreig try) 7 land	
*=		Usual Residence of Decedent  10a. State  10b. County	10c. Cit	tv. Town or Location	on				10	Dd. Inside City Limits	
28a-f sho	Director	MD Baltimo		Arbut	us					1 ☐ Yes 2 🕅 No	
23a or 2	ai Dir	4503 Leeds Ave	nue	1	2122	9	1	0g. Citizen of V USA	Vhat Coun	try?	
marked other than "natural", or items 23s or 28s-4 show imatic event, the Medical Examination must be inclined at	by Funerai	11. Maritel Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decadent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Decedent of s, specify Cut	Hispanic Origin? (Speci pan, Mexican, Puerto Ri Specify:	ify Yes or No- ican, etc.)	Blac	e - America k, White, e Whj	etc.	
netur	eted	15. Decadent's Edu (Specify only highest grad	leation	16a. Decedent	's Usual Occu	pation during most of working ed)	on 16b, Kind of Business/Industry Aerospace				
or than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	-		Maker	961	Manufa			
is marked other	To Be (	17. Fether's Name (First, Middle, Last)  John Lewis	s Evans				18. Mother's Name (First, Middle, Maiden Sumame)  Florence Redding and Number or Rural Route Number, City or Town, State, Zip Code)				
		19e. Informant's Name/Relationship (T)	rpe, Print)	19b. Mailing A	ddress (Stree	t and Number or Rural	Route Number	City or Town,	State, Zip	Code)	
r other		Doris H. Evans	20b. F	4503 Place of Dispositio	Leeds in (Name of ary or other pla	Ave. Arb	utus,	MD 21	229 City or To	wn, State	
luny		4 ☐ Donation 5 ☐ Other (Specify)	Me	tro Crema	atory,	Inc. 7/1/9	19	Baltim	ore,	MD	
any injury o		21. Signeture of Funeral Service Licens	$\mathcal{O}($	20	O Ero	ซห <sup>เร</sup> รีซciet derick Rd	y of	Maryla	nd,	Inc.	
		Edward A. Fit 23a. Parti. Enter the disease, or compl shock, or heart failure. List only o	egorchik ications that caused the daat	h. Do not enter th	e mode of dy	ing, such as cardiac or	respiratory arre	est,		Approximate Interval Between	
ician										Onset and Death	
licai iner		Immediate Causa (Final disease or condition	. Metasta	fic es	ophas	REAL CAR	CINDA	Ar		amonth	
niei	_	resulting in death)		or as a consequen							
nsit	Examiner		b		,				-		
es the burial-transit	Exa	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (c	or as a consequen	ce of):						
and e	edical	Cause (Disease or injury thet Initiated events	Due to (o	r as e consequenc	ce of):						
9 85 th		resulting In death) Last	·						i		
for use	lan		d				-				
be detached for use	Physician/M	Part II. Other aignificant conditions con	ntributing to death but not res	ulting in the under	lying cause gi	iven In Part I.	23b. Did to	bacco use coi	ntributa to	the cause of death	
deta		ChRONIC AY	rdif laist	Hallis	ONG		1 🗆 Y	s 2 No	3 Prob	ably 4 Vinknov	
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N	Completed	JAMA INDUIL	ochemies	JI CHIHI		MEIII 102	penom		con	npletion of cause leath?	
g.	Con						1 □ Ye	s 2 No	1 🗆	Yes 2□ No	
ector,	Be	25. Was case referred to medical examiner?	to a with a t			26. Place of Death (	Check only on	э)			
Ö	T.	1 Yes 2 No			DOA	her: 4 Nursing Home		-		)	
fune	tion	27. Manner of Death  1 ■ Natural 5 □ Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju Wo	rryat 28 ork? ]Yes 2 □ No	a. Describe ha	w injury occurr	ed		
by the	fica	3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome, farm, street.			f. Location (St	reet and Numb	er or Rum	Route Number.	
Jul De	Certification:	4 Homicide	building, etc. (Specif	y)			City or Town			· · · · · · · · · · · · · · · · · · ·	
tely filte	edicai	29a. Certifier (Check only one)	sician: To the best of my kno- ner: On the basis of examinal and manner stated.	wiedge, death occ tion and/or investi	curred at the ti gation, in my	me, date and place, and opinion, death occurred	d due to the ca at the time, da	use(s) and ma ite and place, a	nner as sta and due to	ated. the cause(s)	
9 1	Θ .	29b. Signature and title of cartifier	Α ο		29c. Licen	se number	25	d. Date signed	d (Month, L	Day, Year)	
ejdwo	Σ	RO	Horling	MD	DB	5609		July	1,1	999	
comple	Σ	Naviana									
	Σ	30 Name and address of person who co	na 1120 N	1. Rolli	ng Rd	1. Baltin	ione, l	ND 2	229	8	
within 24 hours efter death.  To the Funeral Director: After this completely filled in by the funeral completely filled in the funeral comple	æ æ	30 Name and address of person who compared to a second sec	myleted cause of death (Item	1. Rolli	ng Rd	1. Baltin	ione, l	udd 2	229	8	



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q

_						Certificate		Death		Reg. No.	22 6	1010
П	Physici	ian	1. Decedent's Neme (First, Middle, Last Mildred Elizabet		1				2. Date of De Month July	eth 1, I9	QQ Yeer	3. Time of Deeth 5:30 AM
4	/Medi Examir		4e. Facility Neme (If not institution, give				-	4b. City, Town, or Lo			County of Deeth	
	Lxaiiii	161	Genesis Eldercar	e Loch Ray	<i>r</i> en			Towson		-	Baltimo	
	Funerai Director		5. Sociel Security Number 212-07-3512 6. Se	х 7. Age	(In yrs. last bir	Yrs. If Under 1 Months I	Year Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, Da 8 / 17 / 1	th 17. Year) 912	9. Birth Cou Man	plece (State or Foreign untry) Cyland
	and w		Usuel Residence of Decedent  10a. Stete 10b. County		10c. City, Tow	m or Location						10d. Inside City Limits
	Manyle	ro	MD Baltimo	re	Tows							1 ☐ Yes 2 ☒ No
	a or 28a	I Director	10e. Street end Number 8720 Emge Road			10f. Zip C	ode 123	34		10g. Citiz	en of Whet Cou	untry?
020	permit. Peges 1 end 2 should be filed within 72 hours efter death with the Manyland Depertment of Health and Mentel hygiene. Important: if Item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at ance.	by Funeral	11. Marital Stetus  1 ☐ Never Merried 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 25 N It Yes, Give Yeer or Detes:		13. Wes Deceder If Yes, specify		lispanic Origin? (Spen, Mexicen, Puerto Specify:	ecify Yes or No Ricen, etc.)		4. Rece - Amer Bleck, White Specify: Whi	, etc.
Maryland 21215-0020 d 2 should be filed within 72 hours et th and Mentel Hygiene. 7 Is marked other than "naturel", or traumatic event, tra Madical Enart		Completed	15. Decedent's Edu (Specify only highest grad Elementacy/Secondery (0-12)	cation e com <i>pleted)</i> College (1-4or 5-	+)		Occup done retired	petion during most of work d)	ing		d ot Business/li	ndustry
Q 7	Hygie ther th	Co	17. Fether's Name (First, Middle, Last)		H	omemaker	-	18. Mother's Neme	First Middle		Home	
an	id be entei ked o	To Be	Frank Kraus					Francis			arramo)	
Mary	nd 2 shou lith and M 27 is mar	-	19a. Informent's Neme/Relationship (7) Stanley Engleman	vpe, Print)				and Number or Run				
altimore,	Peges 1 elent of Hear of Item it if Item iry or other		20e. Method of Disposition 1 △ Burial 2 □ Cremetion 3 □ F 4 □ Donetion 5 □ Other (Specify)		20b. Plece o cemete Garde	f Disposition (Name ry, crematory or oth ns of Fai	of er plac th	Cemetery	Dete 7/3/99	20c. Loc Balt	ation · City or T	Town, State Maryland
Balti	permit. Depentra Importa any inju		21. Signature of Funeral Service Licens		ss of Fecility Joh Lr Road Ba				21206			
	- 1		23a. Pert1. Enter the disease, or com- shock, or heart failure. List only or	cations that caused ne cease on each lin	the death. Do						Ly Land	Approximete Intervel Between
7	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in deeth)	A	remis						1	Onset end Deeth
		e	resulting in debtily	θ	Oue to (or es e	consequence of);					1	1-0
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Records,	been should	Completed by							24e. Wes	en eutops ormed?	9	Vere autopsy tindings ivelleble prior to completion of ceuse it deeth?
	The law sate has page 2	Com							1 🗆	Yes 2	No 1	☐ Yes 2☐ No
Viital	ician: The certificate rector, pay	Be	25. Wes cese referred to medical exeminer?					26. Plece of Deet	(Check only	one)		
	ing Phys After this uneral di	P	1 Yes 2 No  27. Menner of Deeth 1 Netural 5 Pending	dospitel: 1 ☐ Inpatien 28e. Dete of Injun (Month, Day	y. 28b.	Time ot 28d	. Injur	y at ***	me 5 ☐ Resi 28d. Descrîbe			ify)
Division of	dee dee ctor	Certification:	2 Accident 3 Suicide 4 Homicide	28e. Piece of Inju building, etc	ry - At home, te . (Specify)	M erm, street, factory, o		Yes 2 No	28f. Location ( City or To	Street and wn, State)	Number or Ru	ral Route Number,
	To the Hospital or A within 24 hours efter To the Funeral Dire completely filled in b	edical C		sician: To the best of nar; On the basis of end menner stat	exemination en							
	within To th	Me	29b. Signeture end title of certifier	12/2		A 29c. 1	Licens	25569		29d. Date	signed (Month	n, Day, Year)
	6		30. Name and address of person who co	ompleted cause of de	eth (Item 23e)	(Typer Print)	10	rk Rb1	Luth	ewe	26,7	ML, 21093
	Sta	ite	31. Dete filed (Month, Day, Xeer)	3550000	CoSoneture	1. dom	6	,		/ <del>-</del>		



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1 Decedent's Neme (First Middle Last) 2. Date of Deeth Fliegel **Physician** 2232 Lillian 30 June /Medical 4e Fecility Neme (If not institution, give streat end number, 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Hospital Randallstown Northwest Baltmore If Under 1 Year | If Undar 24 Hrs. 5. Sociel Security Number 7. Aga (In yrs. last birthday) 8. Deta of Birth (Month, Dev. Year) Birthplaca (Steta or Foreign Country) **Funeral** 1□ M 2X F Months Deys Hours 215-01-2285 Yrs. Director MAR. 6, 1905 RUSSIA Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other trsumatic event, the Medical Examines must be notified at BALTIMORE ty Yas 2 No MD N/A Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3103 BANCROFT ROAD #E 21215 U.S.A. Funeral death 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yas 2 ☒ No
If Yes, Give
Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - American Indian, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiena. Int: If Item 27 is marked other than "natural", or item 1 ☐ Navar Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 X No Specify: WHITE þ 3 X Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) SALESWOMAN HECHT COMPANY 18. Mother's Name (First, Middle, Meiden Sumema) 17. Fathar's Nama (First, Middla, Last) REUBEN **BELLUS** REBECCA (UNKNOWN) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) SANDRA B. ABRAMSON / DAUGHTER 9311 COUNTESS DRIVE - OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State Department of important: if it any injury or o 1 XBuriai 2 Cremetion 3 Removal from State 7/2/99 ARLINGTON CHIZUK AMUNO BALTIMORE, MD 4 Donetlon 5 Othar (Spec 21. Signatury of Pung 22. Nema and Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest heart failure. List only one cause on each line. Approximete Intarval Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Finel diseese or condition resulting in deeth) days · Ischemic Examiner Examiner requires that the death certificate be axecuted Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): pue physician Physician/Medical the Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 1 Yee 2 No 3 Probably 4 Unknown Hypertention PV 24b. Were eutopsy findings eveileble prior to Completed 24e. Was an eutopsy performad? completion of cause of death? 1 Yes 2 No certificata 1 ☐ Yes 2 ☐ No Division of Vital • Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifici funeral director. Be 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1€ Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how Injury occurred Certification: 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicida 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete and plece, and due to the ceuse(s) end manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end mennar stated. 29e. Certifier edical To the Hosp within 24 ho To the Fune completely fi 29d. Dete signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number D35844 DRoggen 30 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

D Roggen 5401 Old CT Rd Resterstown 5401 Old Ct Rd

MD

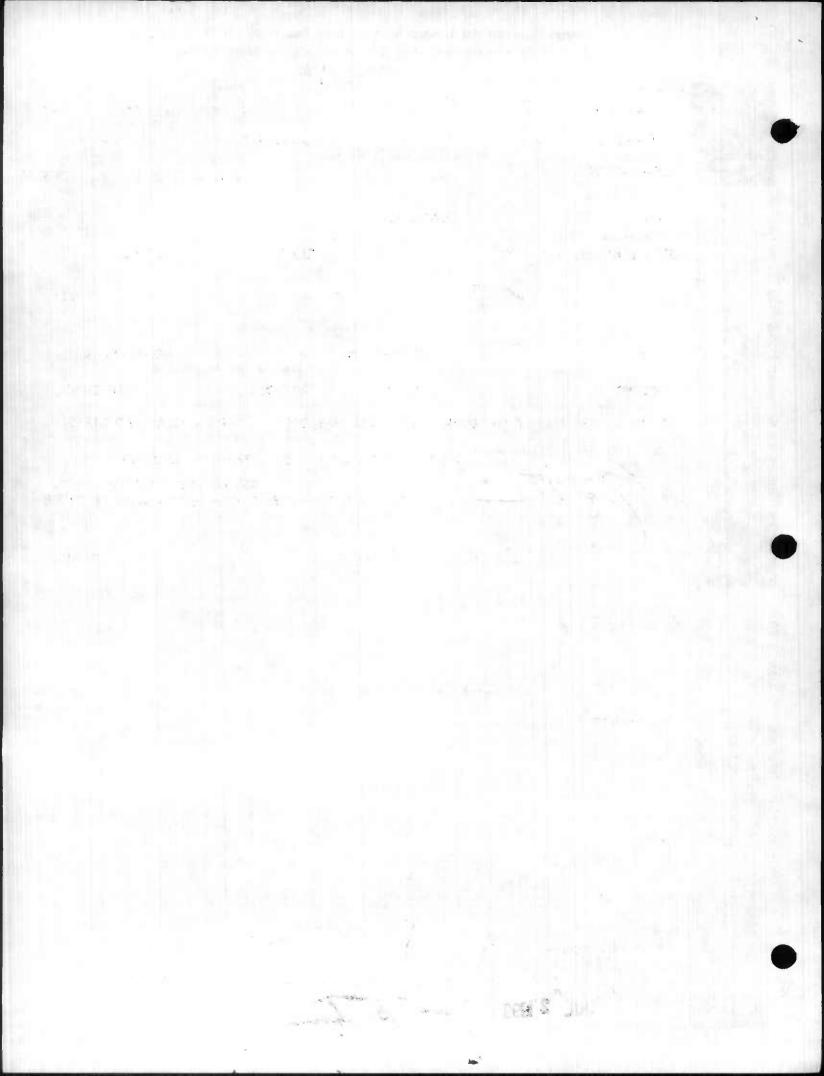
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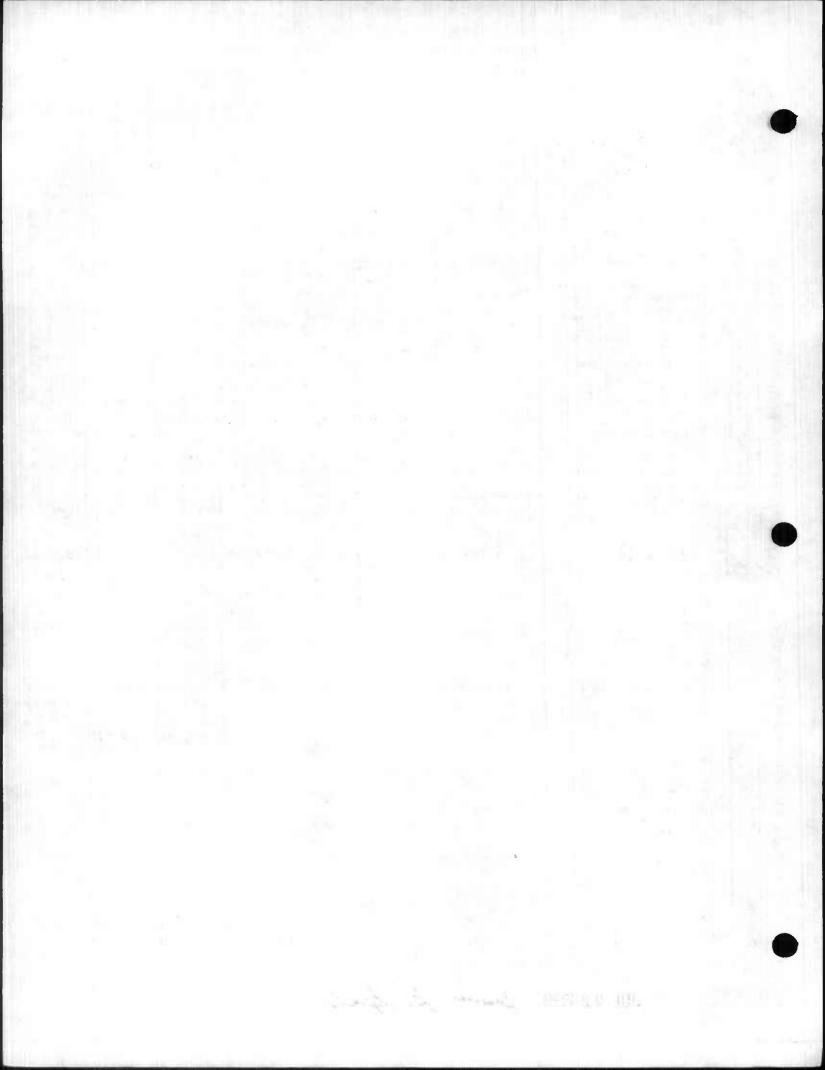
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32. Registra's Signature



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	1. Decedent's Nema (	(First Middle I as	()		Certii	ficate of	Death	2. Date of De	Reg. No.		3. Time of Death			
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/Medical	Shirley 4a Fecility Name (II n						th Oh. Taile as	June	29, 199		6:20 A.			
Examiner								Location of Deat	,					
		dgecrost				Under 1 Year	Baltin   If Under 24 Hrs		N/A					
Funeral Director	5. Social Security Num 217-26-55	60	THE OPE C	e (In yrs. las		onths Days	Hours Min	. (Month, De	14,1930	9. Birthplac Country Mary	Ce (State or Fore			
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T S	Maryland	N/A	\		Į.	Baltimo,	re				¥ Yes 2□			
or 28a-fa te notified Director	10e. Street and Numb	10				10f. Zip Code			10g. Citizen of Wi	nat Country	n			
5 E		ecroft R	oad			2	1206		u. s	. A.				
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pa pa		5. Decedent's Edi	22 0 / 3 3021		16a Decedent	's Usual Occup	etion		16b. Kind of Business/Industry					
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4 4 4	19e. Informent's Neme				11	The same of the			oer, City or Town, S					
	Bernard F		sbana)						ore, Mary					
or other	20a. Method of Dispos		Removel from State	cerr	etery, cremeto	on (Name of ony or other plea	<b>&gt;a)</b>	Date	20c. Location - C	ity or Towr	n, Stete			
ant:	4 Donation 5			Gara	dens of	Faith		7/2/99	Baltimor	re. Mo	aryland			
Department of Heal Important: if Itam 2 any Injury or other DUGE.	21. Signeture of Fune	rel Service Licens	wille	<b>~</b>				Home In	nc. ore, Mary	Pand	01012			
	23a, Part1. Enter the shock, or heert to	disease, or comp	licetions that caused	the death.	Do not enter th	ne mode of dyin	g, such as cardia	c or respiratory a	arrest,	; A	pproximate			
nysician	shock, or heert to	eilure. List only o	ne ceuse on each li	ne.						l o	nterval Between Inset and Deat			
Medical xaminer	Immediate Cause (Fin disease or condition resulting in deeth)	nel	. Me		ATIC		a CA	ncer	-	1	year			
<u>ة</u>				Due to (or a	s a consequer	ice of):								
nin nin	b								i					
physician and s the burial-transit bdical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.													
0.0	resulting in death) Las	Due to (or es a consequence of):  d.												
for for										1				
d by the attending letached for use a Physician/M	Pert II. Other algnifica	int conditions co	ntributing to death b	ut not resulti	ng in the under	rtying cause giv	en in Part I.	23b. Did	23b. Did tobacco use contribute to the co					
been signed by the should be detached should be detached letted by Physic				1							bly 4 Uni			
2 2 2								24a. Was	an autopsy ormed?	availa	autopsy findi able prior to oletion of caus ath?			
page CO								10	Yes 2 No	101	res 2 No			
director, page	25. Wes case referred	to medical					26. Place of De	ath (Check only	one)					
# A M	axaminar?	5 1	lospitei:	nt 2 EF	VOutpatient :	3 DOA Oth	er: 4 Nursing	Home 5 PResi	idence 6 Other	(Specify)				
0 9	1 Inpatient 2 ER/Outpatient 3 DOA 4 Nurs							T	how injury occurre					
5 8	1 PNetural :	2 Accident 3 Suicide 4 Homicide 4 Homicide  28e. Plece of Injury - At home, ferm, street, fact building, etc. (Specify)									Route Number,			
5 8	2 Accident 3 Suicide	6 Could not be determined	building, ef		29e. Certifier (Check only one)  29e. Certifier (Check only one)  29e. Certifier (Check only one)  20e. Certifier (Check only one)  21e. Certifying Physician; To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.									
5 8	2 Accident 3 Suicide 4 Hornicide	determined  Certifying Physics	building, et	examination	dge, death oc a and/or invest	curred at the tin igation, in my o	ne, date end plac pinion, deeth occ	e, and due to the urred at the time,	cause(s) and man date and place, ar	ner as stat nd due to th	ed. ne cause(s)			
5 8	2 Accident 3 Suicide 4 Homicide	Certifying Phy	building, etclan; To the best oner: On the basis of	examination	dge, death oc and/or invest	curred at the tin igation, in my o	pinion, deeth occ	e, and due to the urred at the time,	cause(s) and man date and place, ar 29d. Dete signed	nd due to th	ne cause(s)			
n 24 hours after death. The Funeral Director: After the pletely filled in by the funeral pletely carled a Certification: 1	2 Accident 3 Suicide 4 Homicide  29e. Certifier 15 (Check only one)	Certifying Phy	building, etclan; To the best oner: On the basis of	examination	odge, death oc a and/or invest	igation, in my o	pinion, deeth occ	e, and due to the urred at the time,	date and place, ar	nd due to th	ne cause(s)			
5 8	2 Accident 3 Suicide 4 Homicide  29e. Certifier (Check only one)  29b. Signeture and title	Certifying Physical Example of certifier	building, etc	examination	and/or invest	29c. Licenso	pinion, deeth occ	e, and due to the urred at the time,	date and place, ar	nd due to th	ne cause(s)			
5 8	2 Accident 3 Suicide 4 Homicide  29e. Certifier 15 (Check only one)	Certifying Physical Example of certifier	building, etc	examination	and/or invest	29c. Licenso	pinion, deeth occ	e, and due to the urred at the time,	date and place, ar	nd due to th	ne cause(s)			



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dev Otto Oliver Fiedler June 28. 1999 5:15 p.m. 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth 4640 Bucks School House Road Baltimore County Baltimore Birthplace (State or Foreign Country) If Under 1 Yea If Under Hours 5. Sociel Security Number 7. Age (In yrs. last birthday) B. Dete of Birth (Month, Dey, Year) Deys Months 1 M 2 F 219-07-0555 April 16, 1913 Baltimore, Maryland Usual Residence of Decedent 10c. City, Town or Location 10e. Stete 10b. County 10d. Inside City Limits Maryland Baltimore Baltimore County 1 ☐ Yes 2 ☑ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4640 Bucks School House Road 21237 USA 14. Race - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) NA Elementery/Secondery (0-12) Wholesale Florist Fiedler's Florist 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Otto Paul Fiedler Minnie C. Diegert 19e. Informent's Neme/Relationship (Type, Pnint) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Dorothy A Fiedler (wife) 4640 Bucks School House Road Baltimore, Maryland 21237 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Gardens of Faith Cemetery July 1, 1999 Baltimore, Maryland 22. Neme end Address of Fecility 21. Signature of Funerel Service Licensee Lassahn Funeral Home, Inc. 7401 Belair Road Baltimore, Maryland 21236-4625 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset end Death Immediete Cause (Finel disease or condition resulting in deeth) Due to (or es e consequence of) anteny Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as consequence of) Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown heart failure 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy performed? 2 NO 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) 1 ☐ Yes 21 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined

physician and the burial-trans Box 68760. Records, P.O. Division of Vital this After

Physician/Medical by Completed Be Certification: To

3 ☐ Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

29b. Signeture and title of certifie

Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

ð must be Norms 23a

"natural", or

permit. Pages 1 and 2 should be filled within Department of Health and Montal Hygiero. Important: If hem 27 is merked other than 'n any Injury or other transmerted other than 'n

Physician

/Medical Examiner

72 hours after

Baltimore, Maryland 21215-0020

Directo

Funeral

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Completed

Be

To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After ti completely filled in by the funara

State Registrar **DHMH 16 Rev 6/95** 

Medical

D. H. SHER BOURHE 9101 TVA Franklis 31. Dete filed (Month, Dey, Year)

Shenbourne MD

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

29c. License number

to the best of my knowledge, deeth occurred at the time, date end placa, end due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated.

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

Balto

Physician /Medical Examiner buriel-trar and

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Maryland 21215-0020

altimore,

Peges 1 and 2 should be filled within nent of Health and Mentel Hygiene. nt: if item 27 le marked other than

traumatic event.

other

6 pemit. Pege Department of Important: If eny Injury or Directo

Funeral

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Completed

Examiner Physician/Medical þ Completed Be 2 Certification:

law requires that the death certificate be execu the USB 3 signed be det this funeral After

P.O. Division of Vital Hospital or Attending 24 hours efter death. Funeral Director: Aft 24 hours e

To the To the To the

State Registrar

edical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 Homicide

29a. Certifier

32. Registrar's Signature

asanthalcuma

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. VASANTHA (CUMM MD

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 1999





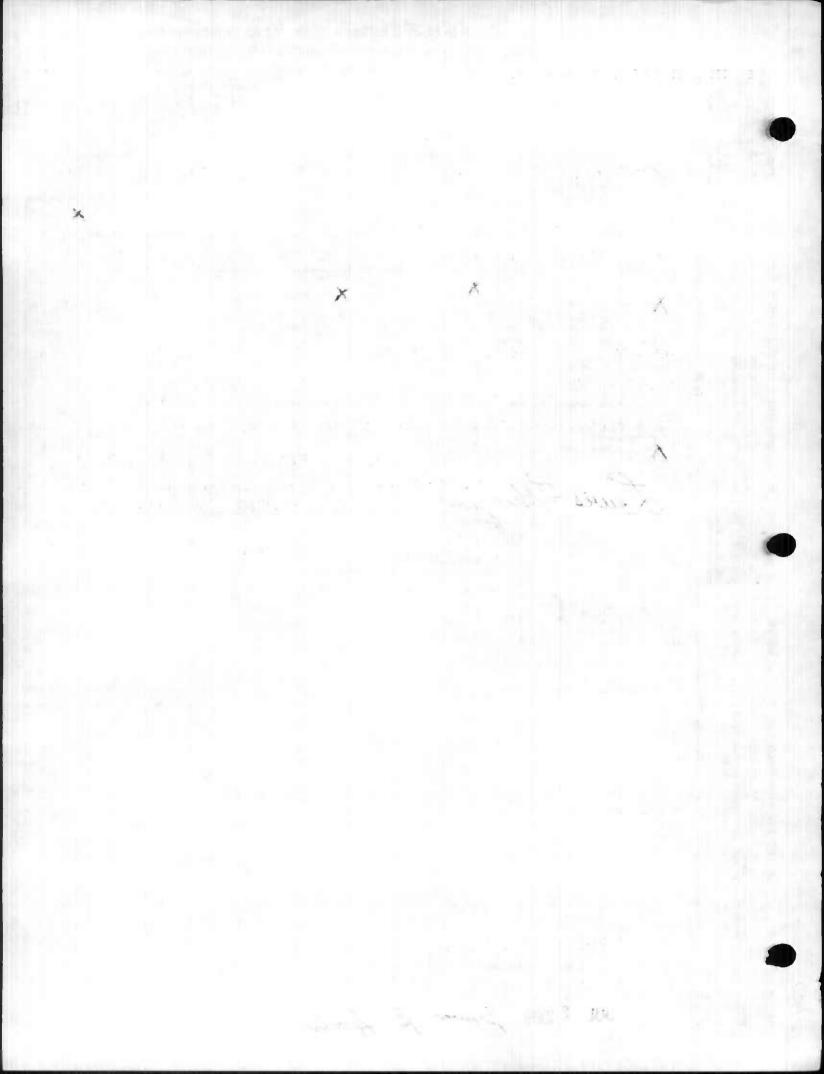
1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29c. License number

D42510

29d. Date signed (Month, Day, Year)

821 N. BUTAWST # 407 MD21201



State of Maryland / Department of Health and Mental Hygiene

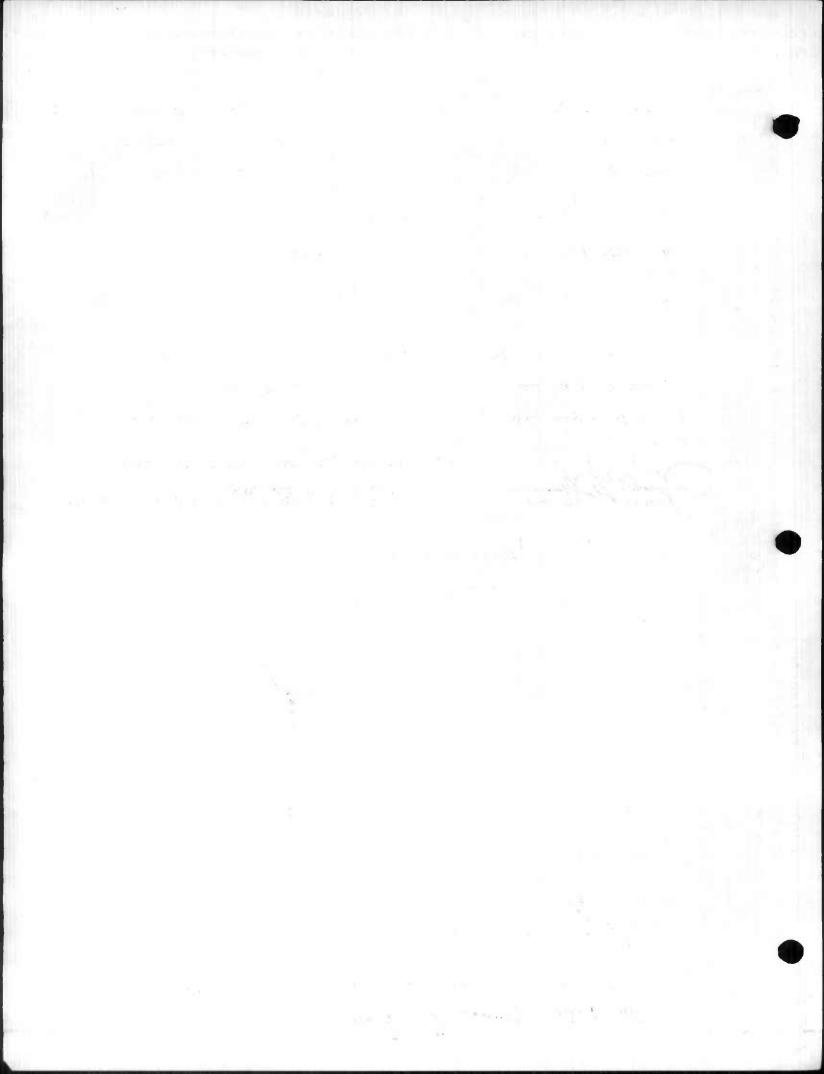
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yeer **Physician** Frances M. Gladys 9:38 am June 30 1999 /Medical 4e. Fecility Name (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Stella Maris Timonium **Baltimore** If Under 24 Hrs. Hours Min. If Under 1 Yeer 5. Sociei Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Feb. 2 Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Deys 140-22-7589 99 Yrs. Director 1900 Austria Usuai Residence of Decedent the Marylend 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examples mail to nothing a MD **Baltimore** Cockeysville 1 Yes 2 No Director 10e. Street end Number 10f. Zin Code 10g. Citizen of What Country? with 2D Silverleaf Ct. 21030 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces? "natural", or items 11 Marttal Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. filed within 72 hours efter Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐No Specify: White à 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elamentary/Sacondary (0-12) Coilege (1-4or 5+) n/a Homemaker Own Home permit. Pages 1 end 2 should be file Depertment of Health end Mentel Hy, Important: If Item 27 is marked othe any Injury or other traumatic event, sonce. 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) Be Theodore Shoemaker Rose Bigus 2 19a, Informent's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marion Zopfi/daughter 2D Silverleaf Ct., Cockeysville, MD 21030 20b. Piece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Deurin 2 Decremention 3 Removal from State 5 DOtter /Spec Saters Baptist Ch. Cem. 7/3/99 Lutherville, MD □ Dod 22. Neme and Address of Facility Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093 Lowell M. Lemmon Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final disease or condition rasulting in death) ARTERIOSCLEROSIS Examiner Dua to (or as a consequance of): Examiner DEMENTIA physician end the buriel-transit the death certificete be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted avents resulting in daath) Lest Dua to (or es e consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequenca of): attending USB č Part II. Other significent conditions contributing to death but not resulting in the underlying causa given in Pert I. the 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably A ☐ Unknown Records, Completed by 24a. Was en eutopsy 24b. Were eutopsy findings avellebie prior to completion of cause of death? been s hes page 2 2 No certificate 1 Tyes 1 ☐ Yas 2 ☐ No Vital Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certification by the funeral director. Be 25. Wes cese rafarred to medicel examinar? 26. Place of Death (Check only one) Hospitai: Other: 4XXXursing Home 5 - Residence 6 - Other (Specify) 10 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA Division of 27. Mannar of Deetl 28a. Data of Injury (Month, Day Year) Certification: 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred 5 Panding invastigation 1X Naturai 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital or A within 24 hours efter To the Funeral Direcompletely filled in b Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) end menner as stated.

2 | the cause | Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the ceuse(s) and manner steted. Medical 29a. Certifier 29b. Signature and 29d. Date signed (Month, Day, Year) 29c. License number -04 6.30.98. D 15504 30. Name and address of person who complated ceusa of daeth (item 23a) (Type, Print) Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093 32. Registrer's Signatura 31. Data filed (Month, Day, Year) State 2 1999 Sparks Registrar

**DHMH 16 Rev 6/95** 

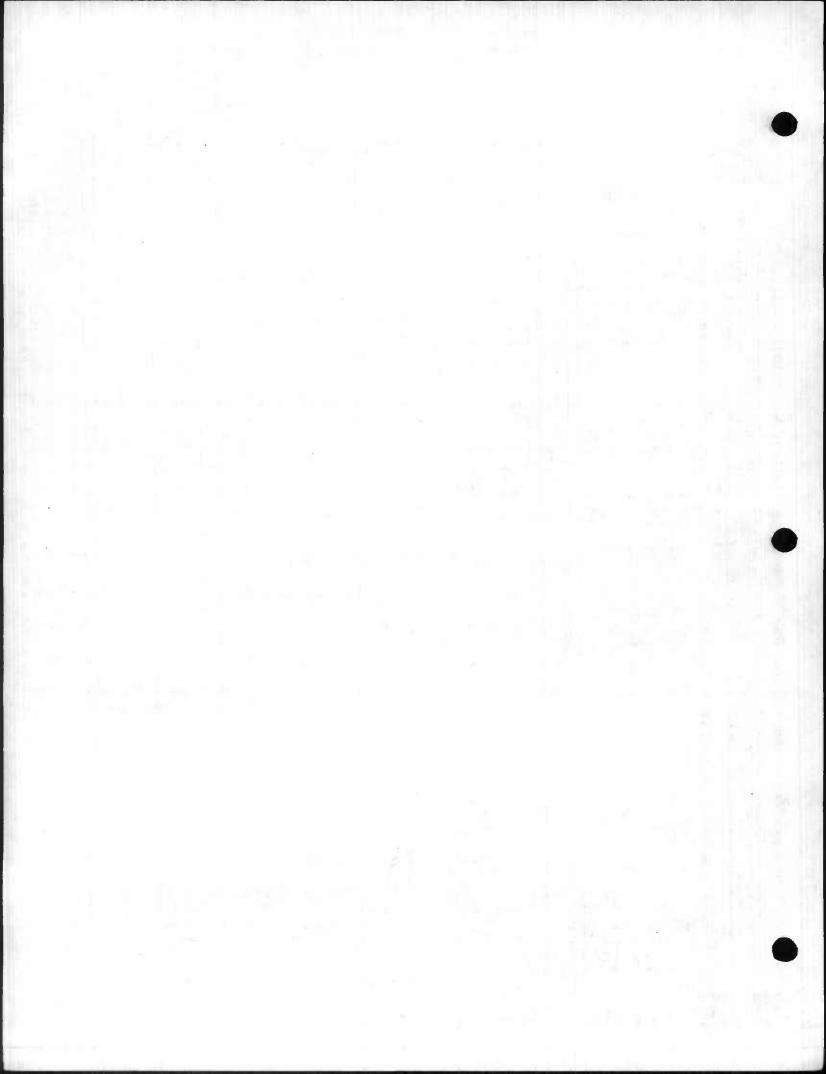
GLADYS, FRANCES

NAME



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

			Certifica	ate of Death		eg. No.		
Physician /Medical	1. Decedent's Name (First, Middle, La  MARYLAND  4a Facility Name (If not institution, give	J. GROGG	3	4b. City. Town, o	2. Deta of Deat Month JUNE r Location of Death	Day		3. Time of Death 5:20 Am
neral	UNIVERSITY OF MI 5. Social Security Number 6.5	ARYLMO MEDI		M BACTIN der 1 Year   If Under 24 Hi	NORES	BACT	7MO ( 9. Birthpla Country	co (State or Fordign y)
Funeral Director	10a. State 10b. County MD N/A		y, Town or Location				100	d. Inside City Limits
Director	10e. Street and Number	n A	10f.	Zip Code 21226	10	0g. Citizen of W		у?
by Funeral	4018 Penningto  11. Marital Status  1 Never Married 2 Merned  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1   Yes 2 ZNo If Yes, Give Year or Datas:	If Yas, s	cedent of Hispanic Origin? pecify Cuban, Mexican, Pue	(Specify Yas or No- into Rican, etc.)	14. Rece Bleck	SA.  - American k, White, et  Whit	C.
Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) UNIX	ducation ide completed) College (1-4or 5+)	16a. Decedent's U (Give kind of life. DO NOT	work done during most of w Fuse retired)	orking	16b. Kind of Bus		stry
900	17. Father's Name (First, Middle, Last, UNK .				eme (First, Middle, M			
F	19a. Informent's Name/Reletionship (  Betty J. Thaye  20a. Method of Disposition  1□ Burial 2 ②Cremation 3 □	r/daughter	1543 Co Plece of Disposition (formeterly, cremeterly)	or other plece)	Baltimo	ore, Mi 20c. Location - (	D 212 City or Tow	2.2.3 m, Stete
	21. Signature of Funerel Service Licenter of Funerel Servi	Mc Donald	22. Nama Cren 299	tory, Inc. 6/ and Address of Facility nation Soci Frederick	ety of M Rd. Balt	timore	nc.	21228 Approximete
	shock, or heart feilure. List only Immediete Cause (Final disease or condition resulting in death)	one cause on each line.		TART FAILURI			1 1	ntarval Between Onset and Death
edical Examiner	Sequentially tist conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or Injury that initieted events resulting in death) Last	· KIDNEY	ALURE or es e consequence o	of):	ense		6	MONTHS
_	Todalily Last	4. BURNWONIE	1				2	MRKI
y Physician/M	Part ff. Other significant conditions of	ontributing to death but not res	ulting in the underlyIn	g cause given in Pert I.		bacco use con	3 Probe	the cause of death?
Completed by					24a. Wes a perform		com	e autopsy findings lable prior to pletion of cause eath?
	25. Wes case referred to medical				1 🗆 Ye		10	Yes 2 No
ation: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Neturat 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey/Year)	ER/Outpatient 3 28b. Time of fnjury	Other:	eath (Check only on Home 5 Reside 28d. Describe ho	ence 6 Othe		
Certification:	3 Suicide 6 Could not b	28e. Plece of Injury - At he building, etc. (Specif	ome, farm, street, fect	lory, office	28f. Location (St. City or Town	reet and Numbe n, Stete)	er or Rural	Route Number,
Medical Certif	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno niner: On the basis of examine and menner steted.	wiedge, deeth occurre tion and/or investigati	ed et the time, dete and ple- on, in my opinion, deeth oc	ce, end due to the ca curred at the time, da	ause(s) and mer ate and place, a	nner as sta and due to t	ted. the cause(s)
M	29b. Signifium and this of Partifier	N CA		29c. Licansa number P10218	2:	9d. Date signed	(Month, D	9, Year)
	30. Name and address of person who	completed cause of death (Item	n 23a) (Type, Print)		alsust	Puna T	3.4	Mel



		State of Maryla		Certificate				ng. No.	2	025	
an	Decedent'a Neme (First, Middle, Last)						2. Date of Deat Month	Dav	Year	. Time of Deal	
il il	Suzanne M.	Grylewicz					June 30	1999		7:05 A	
	4e Facility Name (If not institution, give :				4	1b. City, Town, or		4c. County			
	12 Hardwood D					Baltimo			altimor		
	212-84-1020	7. Age (In yn	s. last birthe	Months	Days	If Under 24 Hrs Hours Min.	8. Dete of Birth (Month, Day, Sept. 8	Year) 1935	9. Birthplace Country) Induc	(State or For	
TOTAL TOTAL	Usual Residence of Decedent  10a. Stete 10b. County  Maryland Baltimor		City, Town o	or Location	Во	ultimore				Inside City Lir	
	10e. Street and Number 12 Hardwood Driv	ve		10f. Zip (		1237	1	10g. Citizen of What Country? U.S.A.			
	11. Meritel Stetus	12. Wes Decedent Ever in	U,S.	13. Wes Decede	ent of H	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No-	Yes or No- n, etc.) 14. Race - Amer Bleck, White			
	1 Never Married 2 Merried 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Yeer or Detes:		1 ☐ Yes 2		Specify:	o Picari, etc.)	Specif		ite	
	15. Decedent's Educ (Specify only highest grade	cation	16a. D	ecedent's Usual	Occup	ation during most of wo	rkina	16b. Kind of B	usiness/Indus	ry	
	Elementery/Secondery (0-12)	College (1-4or 5+)	· II	Homemak	retired	doning most or wo	A#79	Owi	Own Home		
	17. Father's Name (First, Middle, Last)  Maurice Thorn	ton				18. Mother's New Helev	ne (First, Middle, M L Rock	Aaiden Surnar	пө)		
	19e. Informant's Neme/Reletionship (Type	pe, Print)	19b. A	Aeiling Address	Street	and Number or Ri	ıral Route Number	City or Town	, State, Zip Co	de)	
Ì	Benedict Grylewic	z (husband)	12	Hardwoo	d I	Prive, Bo	eltimore,	Maryle	and 2	1237	
2	20e. Method of Disposition  1 Burial 2 Cremetion 3 R 4 Donetion 5 Other (Specify)	emovel from State	cemetery.	cremetory or oth	ner pled	wsoleum			City or Town		
	21. Signeture of Funeral Service License		ucune	22 Name and	Addro	on of Engility	Home, Iv Baltimore			grana	
Im	23a. Pert1. Enter the disease, or complessock, or heart failure. Little on	nations that caused the de	eth. Do no	9705 B	ela	Ut Kd.,	Baltimore	, MV 2	1236	oravimata	
	shock, or heart failure. Caron,  Immediate Cause (Final disease or condition resulting in death)	METAS	TATI	c Co.	~DX	1	LINOMA		lot or	proximate erval Between iset and Death	
	Due to (or as e consequence of):										
	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Disease or Injury	Due to	(or es e cor	nsequence of):							
clan/Medical Ex	that initiated events resulting in death) Last	Due to	(or as e cor	nsequence of):							
	Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.						23b. Did tobacco use contribute to the cau				
	Pert II. Other algnificant conditions con										
	Pert II. Other algnificant conditions con						24a. Wes a perform		availa	autopsy findin ble prior to etion of cause th?	
١	Pert II. Other algnificant conditions con						24a. Wes a	ned?	availa compl of dea	ble prior to etion of cause	
	25. Was case referred to medical					26. Place of De	24a. Wes a perform	ned?	availa compl of dea	ble prior to etion of cause th?	
in accordance of	25. Was case referred to medical	lospitel: 1 □ Inpatient 2 (	□ ER/Outp	atient 3□ DO/	Oth		24a. Wes a perform	ned?	availa compl of dea	ble prior to etion of cause th?	
cermication. To be completed by hillysteralisme	25. Was case referred to medical examiner?	lospitel: 1 ☐ Inpatient 2( 28a. Dete of Injury (Month, Day Year)	28b. Tin	ne of 28	c. Injur Wor	er: 4 Nursing h	24a. Wes a perform	ned?  ps 2 No  p)  phoce 6 □Ott	availa comploi des 1  Y	ble prior to etion of cause th?	

Division of Vital Records, P.O. Box 68760,

State Registrar

DHMH 16 Rav 6/95

DIANA H. (Q) 31. Date filed (Month, Dey, Year) JUL 0 2 1999

29c. License number

29d. Date signed (Month, Dey, Year)
JUNE 30, 1999

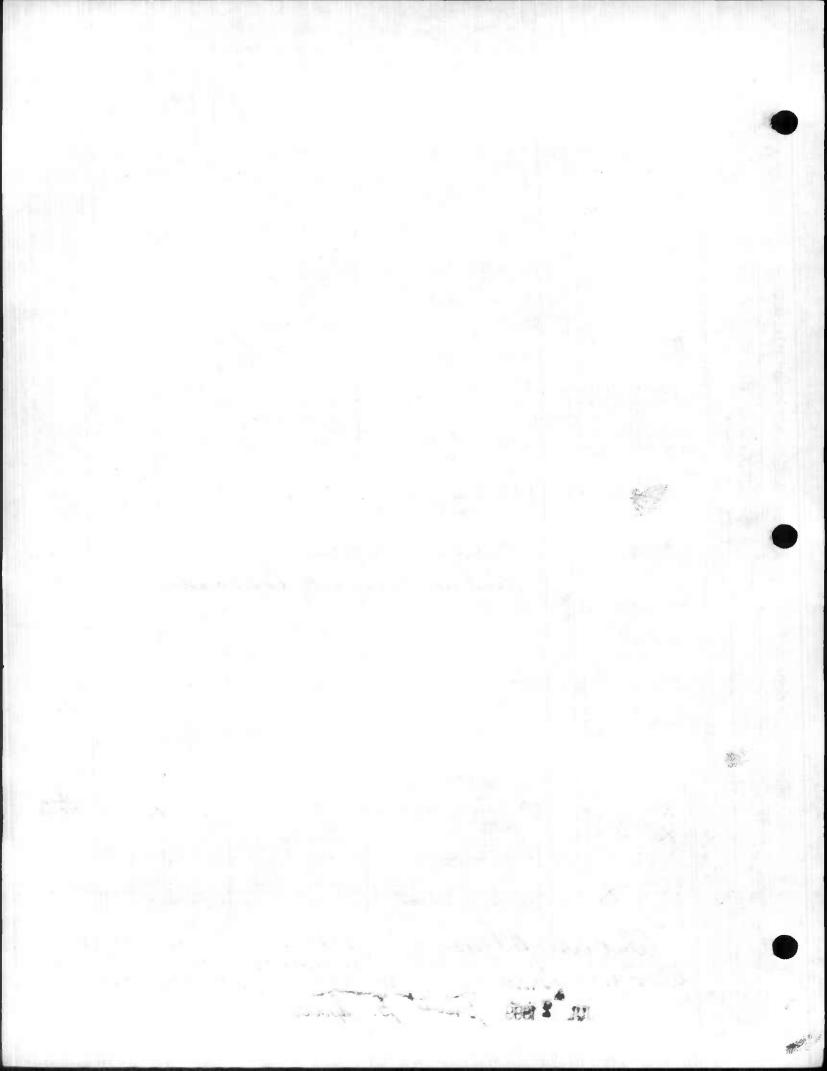
ANE. BALTIMORE, HD. 21229

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State of Maryland / Department of Health and Mental Hygiene 99 2 | 026

Certificate of Death

46 Facility Name (If not institution, give street and number)  927 BTUTISMICK Street  N/A  100 Street and Number  100 State   100 County   100 City, Town or Location   100 Mary   100 Mary						Cer	tificate	e of l	Death		R	eg. No.			
Social Security Name (if not statistics, plus about and number)  327 BYUNSWICK STREET  1. Social Security Number  2. Social Security Number  1. Social Security Number  2. Social Security Number  1. Social Secur		1. Decedent'e Name	(First, Middle, La	ist)									Veer	3. Time o	A Death
927 Brunswick Street  928 Brunswick Street  100		Ralph		Gille	spie					J	UNE	29,	1999	9:	50 AI
2 Social	aminer	4a Facility Name (#	not institution, gi	e street and numb	er)			4	b. City, Tov	vn, or Local	tion of Death	4c. Cou	nty of Deeth		
216-52-4437  100 Mary Land  100 Copy, Town or Location  101 Mary Land  102 Mary Land  103 Mary Land  104 Mary Land  105 Mary Land  105 Mary Land  105 Mary Land  106 Mary Land  107 Mary Land  107 Mary Land  108 Mary Land  109 Mary Land  109 Mary Land  100 Lands Cr.  101 Mary Land  109 Mary Land  100 Lands Cr.  101 Mary Land  100 Lands Cr.  102 Mary Land  103 Mary Land  103 Mary Land  104 Mary Land  105 Mary Land  105 Mary Land  106 Mary Land  107 Mary Land  107 Mary Land  107 Mary Land  108 Mary Land  109 Mary Land  109 Mary Land  109 Mary Land  109 Lands Cr.  100 Lands Cr.  1		927 Brun	swick St	reet					Balti	more			N/A		
Total Country   Total Countr	eral	5. Social Security Nu			Age (In yrs. la.	st birthday)	The same of the sa			4 Hrs. 8.	Date of Birth	Veer	9. Birtho	lace (Stete	or Foreig
Total Service And Number   Total Control   T	ctor	216-52-4	437	IDM 2DF	49	Yrs.	MORIETIS	Days	Hours						
MD Baltimore N/A  10/ Zip Code  100, Sinest and Number  704 Braesdad Rd.  21229  110, Market Status 11 New Procedure of Execution 12 New Procedure of Execution 13 New Procedure of Execution 15 New Procedure of Execution 16 New Procedure of Execution 16 New Procedure of Execution 17 New Procedure of Execution 18 New Procedure of Execution 19 New Procedure of Procedure 19 New Procedure 19 New Procedure of Procedure 19 New Procedure of Procedure 19 New Procedure 19 New Procedure of Pr			Decedent									1000	11111	10,10	
Total Braeside Rd.  21229  USA  11. Martial Stablus  Lywas Decodert Ever in U.S.  11. Martial Stablus  Lywas Decodert Ever in U.S.  12. Was Decodert Ever in U.S.  13. Yes Decodert of Hispanic Dright (Speaty Yes or No. 14. Race - American Indian, 15. Vers. Speaty)  14. Martial Stablus  Lywas Control of Martial (Stablus)  15. Michael Control of Martial (Stablus)  16. Michael Control of Martial (Stablus)  17	3						ation						1		
Total Comments   Specific   Spe	Š	MD	Balti	more	N//	4								1 Yes	≥ ¥ N
Special Community   Spec	ě	10e. Street and Num	ber				10f. Zip	Code			1	0g. Citizen	of What Cour	itry?	
1   West   20 km   1   1   1   1   1   1   1   1   1	9	704 Bras	eside Rd					212	29				IISA		
Secretary   Specify:	9			12. Was Decede		13. V	Vas Deced			in? (Specif	y Yes or No-		lace - Americ		
Secretary   Specify: White   Specify: White   Specify: White   Specify: White   Specify: White   Specify: White   Specify: Specify: White   Specify: Speci	교	1 ☐ Never Marrie	d 2[X] Married	1 ☐ Yes 2	TYNo .	) If	Yes, spec	ify Cuba	n, Mexican	Puerto Ric	an, etc.)	8	Bleck, White,	etc.	
Tell Content   Education   Content	þ			If Yes, Give Year or Date	98:	1	☐ Yes 2	No XI	Specify:			Spe	city: Wh	nite	
Eugene Gillespie, Sr.  196. Meiror NameRelationship (Type, Pirit)  Christina Gillespie – wife  704 Braeside Rd, Baltimore, Md. 21229  200. Method of Disposition  1 Due late 2 (XCremetion 3 CRemovel from State 4 Donalton 5 College (Specially or Other Jacobs)  1 Due late 2 (XCremetion 3 CRemovel from State 4 Donalton 5 College (Specially or Other Jacobs)  22. Name and Address of Facility  22. Name and Address of Facility  Cary L. Kauffman Funeral Home @ Meadowridge MP, 7/250 Washington Blvd. Elkridge, Md. 21075  23. Part! Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest.  24. Part! Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest.  25. Was case (Final resulting in death) Last  Due to (or as a consequence of):  Cary C. Lauffman Funeral Home @ Meadowridge MP, 7/250 Washington Blvd. Elkridge, Md. 21075  Accountially list conditions, and the such as a consequence of):  Cary C. Lauffman Funeral Home @ Meadowridge MP, 7/250 Washington Blvd. Elkridge, Md. 21075  Due to (or as a consequence of):  Cary C. Lauffman Funeral Home @ Meadowridge MP, 7/250 Washington Blvd. Elkridge, Md. 21075  Accountially list conditions, and the such as a consequence of):  Cary C. Lauffman Funeral Home @ Meadowridge MP, 7/250 Washington Blvd. Elkridge, Md. 21075  Due to (or as a consequence of):  Cary C. Washington M. Last  Due to (or as a consequence of):  Cary C. Washington M. Last  Due to (or as a consequence of):  Cary C. Washington M. Last  25. Was case referred to medical and contributing to death but not resulting in the underlying cause given in Pert I.  26. Place of Death (Check only one)  27. Page of Death (Check only one)  28. Was an autopsy performed?  28. Was an autopsy performed?  28. Was an autopsy performed?  28. Due to lay year year of the performed?  28. Due to lay year year year year year year year ye			15. Decedent's E		270	16a. Deced	ent's Usua	l Occup	ation			16b. Kind o	Business/Inc	dustry	
Eugene Gillespie, Sr.  19e. Informant's Name-Picietiona's (Pype, Print)  Christina Gillespie – wife  704 Braeside Rd. Baltimore, Md. 21229  20e. Rend of Disposition (Name of City or Town, State, Zip Code)  1   Busing Address (Street and Mumber or Aural Roote Number, City or Town, State, Zip Code)  1   Busing Address (Street and Mumber or Aural Roote Number, City or Town, State, Zip Code)  1   Busing Address of Pacility  20e. Rend of Disposition (Name of City or Town, State)  1   Dee Comments of City or Town, State State or City or C	9					(Give I	and of wor	rk done d	turing most	of working					
Eugene Gillespie, Sr.    Sally Ann Garland   Christina Gillespie - wife   704 Braeside Rd., Baltimore, Md. 21229   20a. Method of Disposition   19a. Method of Di	Ē	Elementary/Second	dary (0-12)	College (1-4	or 5+)	For	k Lii	Et O	perato	or		F	ox Fac	torv	
Eugene Gillespie, Sr.  19s. Informants Name-Phelationship (Type, Print)  Christina Gillespie – wife  704 Braeside Rd., Baltimore, Md. 21229  20s. Method of Disposition information 3 Chemovel from State   20s. Place of Desposition (Name of corrections from State)   20s. Place of Desposition (Name of corrections from State)   22s. Name and Address of Facility  21. Signature of Funeral Service I conscious College (Special)  22. Name and Address of Facility  22s. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, increased incide of Printing in death) (Interediate Cause (Final resulting in death) (Interediate Cause (Final cause) (Interediate Cause) (Intere	ŏ	17. Father's Name //	irst, Middle, Last	)				1							
198. Informant's Name-Relationship (Type, Print)   198. Making Address (Street and Number of Paral Route Number, City or Town, State, 2/2 Code)	8														
Christina Gillespie - wife	F					40h Mailin	- 444	(0							
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, increased shock, or heart feature. List only one cause on each line.    Immediate Cause (Final disease or condition resulting in death)														0000)	
23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, including a control of the cause of seach line.    Approximate the mode of dying, such as cardiac or respiretory errest, including the conditions. Sequentially list conditions, a consequence of the cause or conditions. Sequentially list conditions, any, leading to minedate cause. Enter funderlying cause (Disease or injury resulting in death) Last    Due to (or as a consequence of):				spie - wi					Rd., I					- 0	
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23a. Part Tenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, including an account of the proposed of the propo					Balt	cimore	Wash	ning	ton Co	rm i	12/99	Laure	l, Mar	yland	
29a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest.  Approximate across (Final disease or conditions)  International Cause (Final disease or conditions)  If any, leading to minimate across (Final disease or conditions)  If any, leading to minimate across (Final disease or conditions)  If any, leading to minimate across (Final disease or conditions)  If any, leading to minimate across (Final disease or right)  Due to (or as a consequence of):  June to (or as a consequence of):  Jule to (or as a consequence of):  Ju	8	21. Signature of Fun	eral Service Lice	need 00											
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Immediate Cause (Final disease or condition resulting in death)   Dup to (or far's consequence of):   Dup to (or far's consequence of):   Dup to (or as a		shock, or heart	failure. List only	one cause on eac	h line.	DO NOT GIVE	a a a a a a a a a a a a a a a a a a a	o or oyar	g, 55011 tt5 1	JAI (JAI O O )	ospirotory orit	ou,		interval Be	tween
disease or condition resulting in ideath)  Due to (or as a consequence of):  All Contributing in death)  Due to (or as a consequence of):  All Contributing in death)  Due to (or as a consequence of):  All Contributing in death)  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):  1   Yee   2   No   3   Probably   24b. Were autopsy performed?  25b. Were autopsy performed?  25c. Was case referred to medical evaporation of completion of c		Immediate Cause /E	inal	0	1			11	•					2	11
Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a		disease or condition		. / u	Imma	y c	mo	oli	m				i	Luc	chr
Sequentially list conditions, if any, leading to immediate cause. Enter Underfying to immediate cause. Enter Underfying that infelled events resulting in death) Last  Due to (or as a consequence of):  Due to (o	2			1	Due to (or a	s a consequ	uence of):		10	1	-	-	1		
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That intered events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence	=	cause. Enter Underl Cause (Disease or in	ying	c											
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.    23b. Did tobacco use contribute to the cause of the	흥	that initieted events			Due to (or a	s a consequ	ience of):						İ		
25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   1	. <b>∑</b>		L										į		
24a. Wes an autopsy performed?  24b. Were eutopsy final available prior to completion of call examiner?  25c. Was case referred to medical examiner?  1 Yes 2 No  25c. Place of Death (Check only one)  27c. Manner of Death  1 Natural Solicide Investigation  28b. Date of Injury  28c. Injury at Work?  1 Yes 2 No  28c. Injury at Work?  1 Yes 2 No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number o	2			d									1		
24a. Wes an autopsy performed?  24b. Were eutopsy final available prior to completion of call examiner?  1 Yes 2 No 2 No 2 No Yes 2 No 2 No 2 No 2 No Yes 2 No 2 N	10	Part II. Other signific	ant conditions of	contributing to deat	h but not result	ing in the un	derlying ca	ause giv	en in Pert I.		23b. Did to	bacco uee	contribute to	the cause	of deat
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24a. Wes an autopsy performed?  24b. Werre autopsy final available prior to completion of card death?  25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Marpher of Death  1 Natural  28a. Date of Injury  28b. Time of finjury  M 1 Yes 2 No  28c. Injury at Work?  1 Netural  2 Nore autopsy final available prior to completion of card death?  27. Marpher of Death  28a. Date of Injury  28b. Time of finjury  28c. Injury at Work?  1 Yes 2 No  28d. Describe how injury occurred  t the time, date and place, and due to the cause(s) and manner as steted.  28d. Certifier (Check only one)  28d. Location (Street and Number or Rural Route Number of Rural Route Number or Rural Route Number on Rural Route Number or Rural Route Number on Rural Rout	×														•
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Marner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury 4 M 1 Yes 2 No  28b. Time of Injury 4 M 1 Yes 2 No  28c. Injury at Work? 4 Nursing Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred  28d. Describe	ᇴ												24b. W	ere eutopsy	findings
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Marner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury 28b. Time of Injury 3 Suicide 4 Homicide  28c. Injury at Work? 1 Yes 2 No  28d. Describe how injury occurred  28d. Describe how inju	5										perform	ned?	00	mpletion of	
25. Was case referred to medical examiner?  1	5													death?	1
1   Yes 2   No	8										1□ Ye	s 2 N	1[	Yes 20	No
27. Manner of Death 1 Natural 2   Section   28a. Date of Injury   28b. Time of final   28c. Injury at   28d. Describe how injury occurred    8		d to medical							of Death (	Check only on	10)		Made	01	
2 Accident 3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and life of certifier  29c. License number  29d. Date signed (Month, Day, Year)	2		lo	1 LI Inp		R/Outpatient		M	4LI NUI	rsing Home	5 ☐ Reside	ence 6	Other (Specif	y) He	me
2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 29e. Certifier (Check only one) 29b. Signature, and life of certifier 29c. License number 29d. Date signed (Month, Day, Year)	Ë		5 Dending	28a. Date of (Month,	njury Day Year) 2		2	8c. Injun World	rat k?	280	d. Describe ho	ow injury oc	curred		
29a. Certifier (Check only one)  29a. Certifier (Check only one)  Continued to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.  Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.  Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and due to the	atio	2 ☐ Accident	investigatio	n			M.	10	Yes 2□P	No					
29a. Certifier (Check only one)  29a. Certifier (Check only one)  Control on the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner as steted.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)				286. Place of	Injury - At hom	e, farm, stre	et, factory	, office		281			mber or Run	I Route Nu	nber,
29a. Certifier (Check only one)  29b. Signature and tiffe of certifier  29c. License number  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.  29b. Signature and tiffe of certifier  29c. License number  29d. Date signed (Month, Day, Year)	5			Donai Ig.	oto. (Opecity)						ony or rom	, 01210/			
29b. Signature and life of certifier 29d. Date signed (Month, Day, Year)	-		Certifying Ph	ysician: To the be	st of my knowl	edge, death	occurred a	at the tin	ne, date and	place, and	due to the ca	ause(s) and	manner as s	teted.	
29b. Signature and lifte of certifier 29d. Date signed (Month, Day, Year)	9			niner: On the basi	s of examinatio										s)
in the state of th		29b. Signature and ti	te of certifier	1	1		29c	License	number		2	9d. Date sic	ned (Month.	Day, Year)	
Win Culaling of 1997	≥	///	11.1	110	man		1	120	1251			-			
	2		1 ///6	lifted 1	10		1	107	77 K	7	9	Jun	07	1777	
30. Name and address of person who continued cause of death (Item 23a) (Type, Print) St Agncs Conces Centes	Σ	Com	Cover												
WM. C. WATERFIELD MD 900 Caton Au Bolt Md 21229		30. Name and address	ss of person who	cooppleted cause of	of death (Item 2	3a) (Type, F	Print) S	+ 4	gnes	Can	ces Ce	entes			



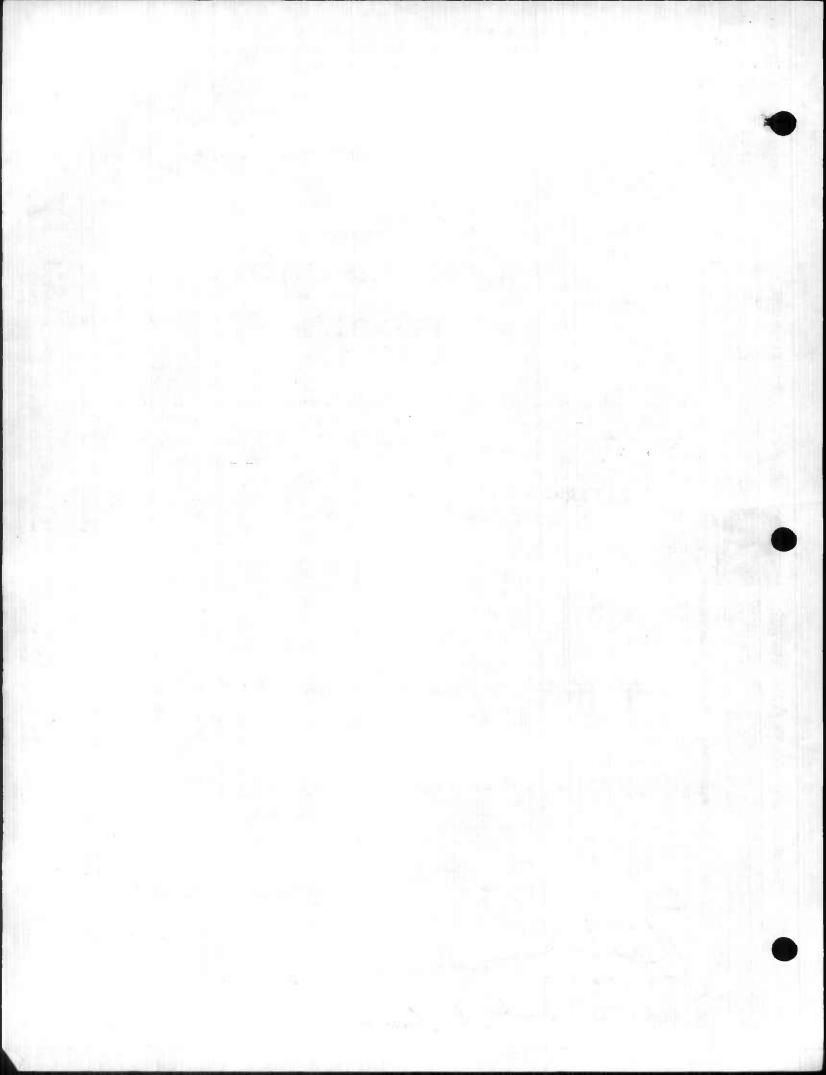
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State of Maryland / Department of Health and Mental Hygiene 99 2 1 0 2 7

Certificate of Death Reg. No.

MA	URICE GH	EE			Cei	rtificat	e of	Death			Reg. No.		, 0 1., 1	
	Physician	1. Decedent's Name (First, Mide		۰. ۸	Chas					2. Date of De Month JUNE		Year 99	3. Time of Death 0752 AM	
7	/Medical Examiner	4a Facility Name (If not institution 3101 SWAN DI	on, give street and nun		Ghee			4b. City, To BALT		ocation of Death				
	Funeral Director	5. Social Security Number 219-90-1466	6. Sex 10 M 2 F	7. Age (In yrs. 21	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Dete of Bir (Month, Da	1-1977	9. Birthp Coun	olace (State or Foreign http) Md	
	show at at	Usual Residence of Decedent  10a. State 10b. Count			ty, Town or Lo							1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	ther death with the Maryland there 23e or 28e-f show inner must be notified at Funeral Director	Md 10e. Street and Number 5103 GWynn Oal	N/A Avenue		Baltimo	10f. Zip					10g. Citizen of V	Vhat Coun	^	
_	ors after af, or its Examine Dv Fui	3 ☐ Widowed 4 ☐ Divorce	12. Was Dece Armed For ried 1  Yes	2 No e			dent of the	lispanic Ori an, Mexicar Specify:		ecify Yes or No Rican, etc.)	- 14. Rac Blac	e - Americ ck, White, y: Blac		
	within 72 h ene. the Medical	15. Decede (Specify only hight Elementary/Secondary (0-12) 12th grade	nt's Education est grade completed)  College (1	-4or 5+)		dent's Usua kind of wo DO NOT us INSE 10	rk done se retire	eation during mos d)	t of work	ing	16b. Kind of Bu	usiness/Inc	dustry Unknown	
nd	should be filed nd Mental Hygi marked other umatic event, I To Be Co	17. Father's Name (First, Middle								e (First, Middle, e Lee-G	Maiden Suman ibbs	10)		
	hard 2 sho fealth and in 27 is ma	19a. Informent's Name/Retation Stephanie Lee-			5103	Gwyr	in 0	ak Av		Balti	more, M			
-	Pages ment of H ant: If he lury or of	20a. Method of Disposition 1/ Burial 2 Cremation 4 Donetion 5 Other (	Specify)	State	Place of Disponentery, cremetery, cremetery	metory or o	Par	k		-3-99	Randal			
Ba	Depart Depart Import any in	21. Signatura of Funeral Service	elle	Cir	SW	Marc 4300	ch F	/H We abash	st Ave	nue Ba	ltimore	, Md	21215	
	Physician /Medical Examiner	23a. Part 1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a	ASPHY								1	Approximate interval Between Onset and Death	
ox 68760,	requires that the death certificate be associed some signed by the attending physician end should be detached for use as the bunsi-transit eted by Physician/Medical Examiner		c		or as a conseq									
7.0. BO	v requires that the death or been signed by the attend should be detached for us technology. Physiciary	Pert II. Other algnificant conditi									ontribute to the cause of death			
ds, P	signed b						-				Yee 25 No an autopsy		bably 4 Unknown ere autopsy findings	
Hecords,	2 2 g									perfo	rmed?	co	allable prior to impletion of cause death?	
- 1	ysicien: The list certificate his director, page	25. Was case referred to medical examiner?	al					26. Place	e of Deat	h (Check only o	Yes 2 No	XX	Yes 2 No	
TO U	2 2 2	1 ☑ Yes 2 ☐ No  27. Manner of Death 1 ☐ Natural 5 ☐ Pendi	28a. Dete o		ER/Outpatier 28b. Time of Injury	2	8c. Inju	y at		28d. Describe	dence (XXX) the how injury occur. WAS AS	red		
Division of	na for Atlanding Pro is after death.  al Director: After the led in by the funeral  Certification:	2 Accident Invest 3 Suicide 6 Could 4 Homicide detern	not be nined 28e. Ptace buildin	6/25/90 of Injury - At hing, etc. (Specif	0742 ome, ferm, str V) UNKNOW	eet, factory		Yes 2 ₩	No	28f. Location ( City or To	Street and Numb	per or Rura 01 SW	AN DRIVE	
	within 24 hours after d To the Funeral Direct completely filled in by		ng Physician: To the Examiner: On the ba end menn	sis of examine		vestigetion.	in my c					and due to	o the ceuse(s)	
	= 3 F 8	Mander	le	of death (tree	n 22a\ /Tuna			M.E.				29, 1		
		Laron Locke	M.D.	11	ll Penr		et,	Balt	imor	e, Mary	land 21	201		
	State Registrar	JUL 0 2 1999	Senevas	egistrar's Signa	ature	.,								

S AND



Division of Vital Records, P.O. Box 68760,

The law requires that the death certificete be executed use the signed by t peen certificate has To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, it

Regis DHMH 16 Rev 6

**Physician** 

Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23e or 28e-f show traumatic event, the Medical Examinar must be notified at

permit. Peges 1 and 2 should be liled within 72 hours after c Department of Heelth and Mentel Hygiena. Important: if item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Examine

**Physician** 

/Medical

Examiner

physician end s the buriel-transit

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Examiner

Physician/Medicai

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Completed

Saltimore, Maryland 21215-0020

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/Medical

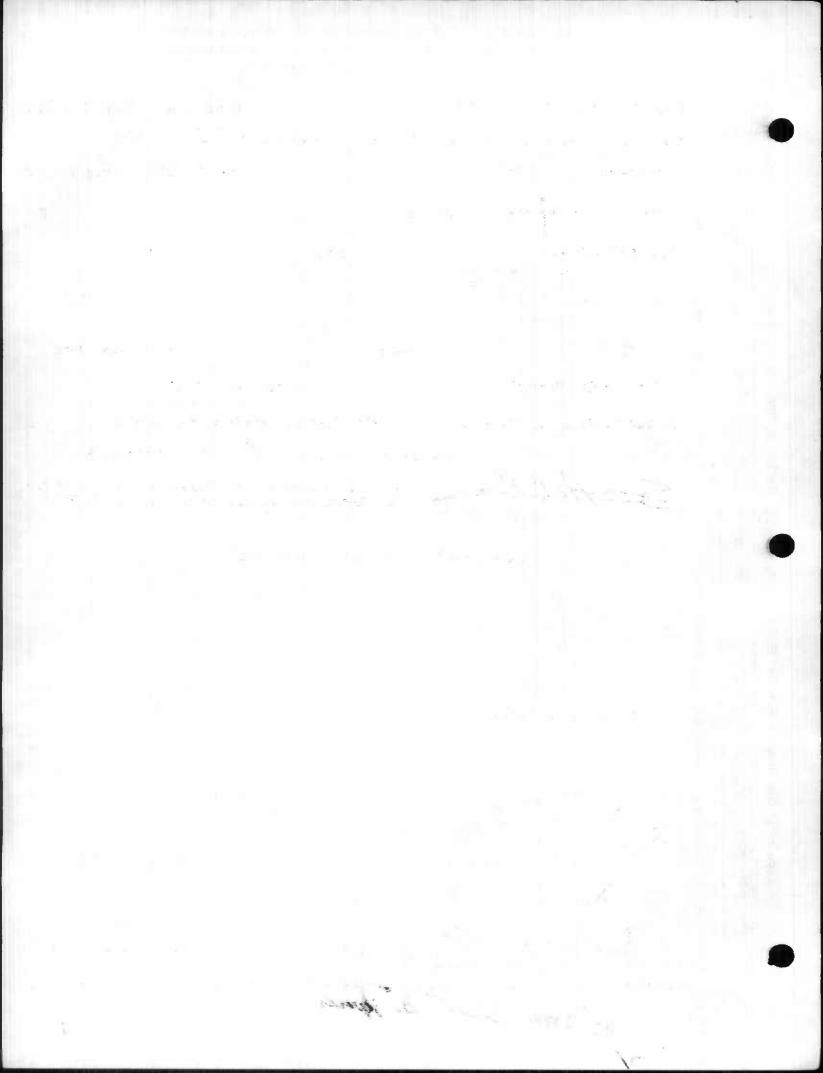
Director

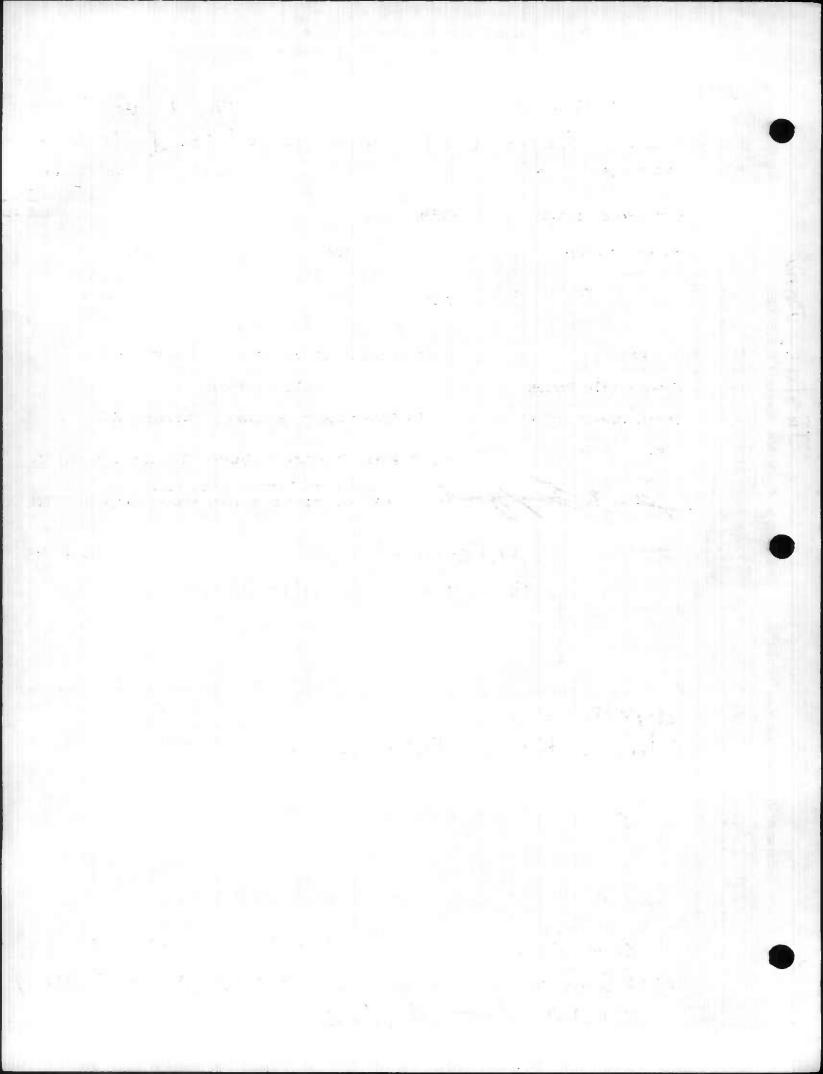
Funeral

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Completed

Be	25. Was casa raferred to medical			26. Placa of De	ath (Check only ona)	
To	axaminar? 1 ☐ Yes 2 No	Hospital: 1 Inpatiant 2	ER/Outpatient 3□ DOA	Othar: 4 Nursing	Homa 5 ☐ Rasidanca 6	3 ☐Other (Specify)
	27. Mannar of Death  1 Natural 5 Panding 2 Accidant invastigation		28b. Tima of Injury M	Injury at Work? 1 Yes 2 No	28d. Describe how injury	y occurred
Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28a. Place of Injury - At h building, atc. (Specia	ome, farm, straat, factory, o	ffice	28f. Location (Street and City or Town, Stata)	d Number or Rural Routa Number,
Medical (		yelclan: To the best of my knowniner: On the besia of axamina and mannar stated.				and manner as stated. placa, and due to the cause(s)
2	29b. Signature and title of certifier	Kanbhatta	M.D BP	QA P120		a signad (Month, Day, Year)  VIE 98 1999
	30. Nama and address of person who	complated cause of death (Iter	n 23a) (Type, Print)			
	SUMABALA KASI	BHOTLA 30	DA S. MANDS	ER ST. B	ALTIMORE	MD 21045
ate rar	31. Date filad (Month, Day, Year)	32 Registrar's Signa	B. Apre	h		
95	JUL 2 13	33 /				





Piease Type or Print in Biack indelible ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death BENNIE JUNE JUNE KEARSE Physician 9:30 P.M /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RALTIMORE ST AGNES HOSPITAL If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 10/M 20 F S.C. Yrs. 220-20-3026 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Baltimore 1 Yas 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? 8 2828 Brighton 21216 U.S-A Street Name 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltlmore, Maryland 21215-0020 "natural", or 1 Yes 2000 Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Apartment Peges 1 and 2 should be filed within it and of Health and Mental Hyglene. Int: If Nem 27 is marked other than "I my or other traumade event, the Men Elementary/Secondary (0-12) College (1-4or 5+) complete Bachelor Degree Supervisor th grade 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 8 Benny Keanse F. Holley 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19g. Informant's Name/Relationship (Type, Print) SIMMINS 3312 Auchentoroly Balto, Md narles - Friend Terrace 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from Steta Department of Important: If eny injury or page. Garrison Forest Veteran 7-6-99 Owings Mills, Ma 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

Yarch F. H. West

4300 wabasi 21. Signature of Funeral Service Licensee 23a. Part 1. Enfer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate

Approximate Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examine physician and s the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 | Yes 2 | No 3 | Probably 4 | Unknown should be det à Hyponeternie 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28b. Time of 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Naturel 5 Pending investigation n 24 hours effer deeth. He Funeral Director: Ah bletely filled in by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi (Check only one) 29c. License number
1) 369 42

State Registrar

**DHMH 16 Rev 6/95** 

BENNIE

AM

29b. Signature and title of certifier

72. Registrer's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1009, Frederick RD. CATONSVILLE, MD 21228

MO

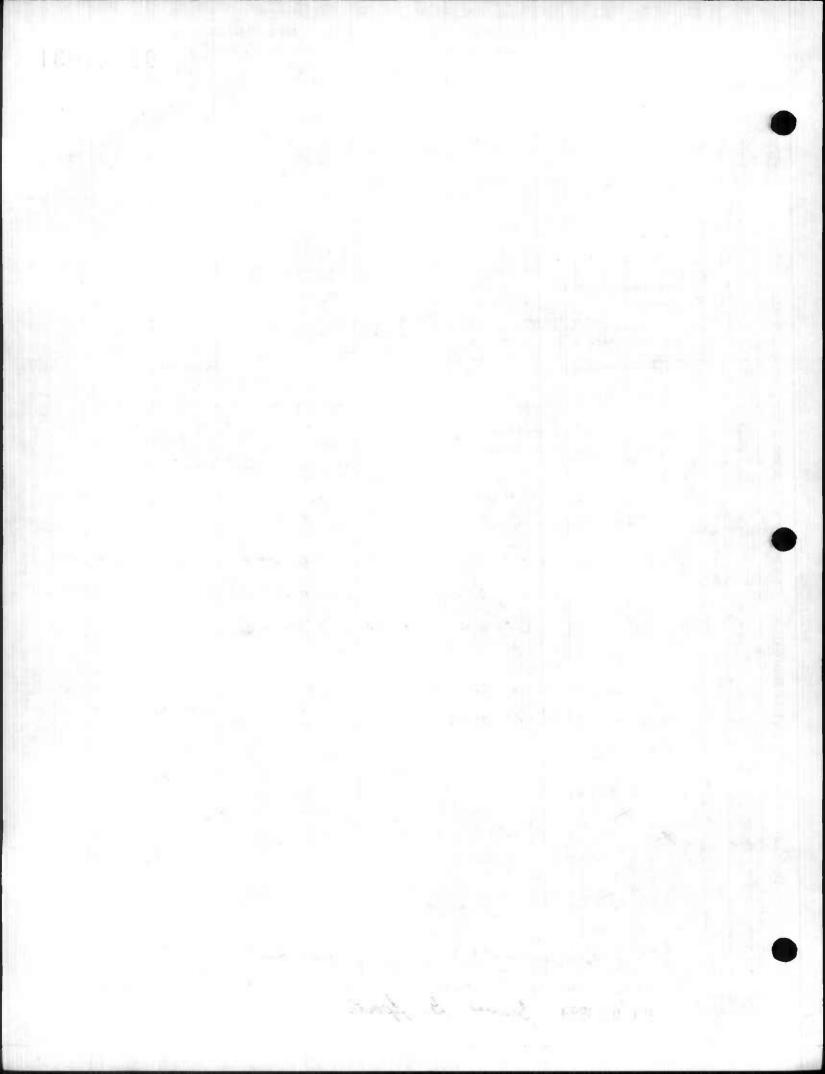
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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 21031

	Certificate of Death		Reg. No.	2 61001	
	1. Decedent's Name (First, Middle, Last)	Death Day	3. Time of Death	•	
Physician /Medical	Olga Kuchta	June		1999 11:30 A.M	
Examiner		, or Location of Dea	ath 4c. County		
		ltimore		N/A	
eral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours I	Min. (Month, L	(Month, Day, Year) Country		
tor	215-38-1255	Dec.	25, 1907	Canada	_
Funeral Director	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits	-
5				1X Yes 2 □ No	
Director	Maryland N/A Baltimore  10e. Street and Number 10f. Zip Code		10g. Citizen of V	Mhet Couetry?	_
era	3710 Eastwood Drive 21206  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	2 (Specify Vec or I	U. S	. A. e - American Indian,	_
Funeral	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces  1 Never Married  1 Yes 2 No  1 No	uerto Rican, etc.)		ck, White, etc.	
by 8	3 Ø Widowed 4 □ Divorced Year or Dates:		Specify	" White	
B	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Bu	usiness/industry	_
Completed	(Specify only highest grade completed) (Give kind of work done during most of	working			
mo	Elementary/Secondary (0-12) College (1-4or 5+) 4th Grade Homemaker		Own	Home.	
O		Name (First, Midd			-
To Be	Demitrof Rybka Ani	na Unk	nown		
-	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of			State, Zip Code)	
	Dolores A. Hill (Daughter) 6 Tipperary Court,				
once.  To Be Comp	20a Method of Disposition 20b. Place of Disposition (Name of	Date		City or Town, State	Egotoon.
	1 M Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)	7/0/00	Darlt'in	to Haturand	
	4 □ Donation 5 □ Other (Specify) Gardens of Faith  21. Signature of Funeral Service Licensee- 22. Name and Address of Facility	17/2/99	baccimo	re, Maryland	_
one	Burn a Willey Schimunek Funer	ral Home	Inc.		
	3331 Brenms Lav	re, Balti	more, Ma		
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car shock, or heart failure. List only one cause on each line.	rdiac or respiratory	arrest,	Approximate Interval Between Onset and Deeth	
an l	Inner day of the Court of the C			Offiser and Deetin	
al er	Immediate Cause (Final disease or condition resulting in death)  a. Is chemic Cardiomy open Due to (or as a consequence of):	thy		Syn.	
No.					
- F	o Myocardial Infactio	7		14 yrs.	
Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events  Due to for as a consequence of the cause of			14 yrs.	
	sequentially 1st conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury C. Coronany Antery Disease or Injury	Ne		lyns	
Medical	resulting in death) Last  Due to for as a consequence of				
	d				
lan					
by Physician	Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f.	23b. Df	d tobacco use co	ntributa to the cause of death?	
F.	Atrial Fibrillation	1(	Yas Mo	3 Probably 4 Unknown	ı
d by P		_		T	_
Completed	Stroke		as an autopsy rlormed?	24b. Were autopsy findings available prior to completion of cause	
ğ				of death?	
S		1 [	Yes 2 No	1 ☐ Yes 2 ☐ No	
To Be Com	25. Was case referred to medical aximiner?	Deeth (Check only	y one)	1	
2	Hoenital:	ing Home 528e	sidence 6 Oth	ner (Specify)	
	27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work?	28d. Describ	e how injury occur	red	
atic	1) Salatural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No				
. P	3 Suicide 4 Homicide  6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Numb own, State)	per or Rural Route Number,	
Certification:	4 Homicide building, etc. (Specify)	Only of 1	Ovin, State)		
	29a. Certifier Tecrtitying Physician: To the best of my knowledge, death occurred at the time, date and p	place, end due to th	ne cause(s) and ma	anner as stated.	
Medical Certifical	(Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death one)	occurred at the time	e, date end place,	and due to the cause(s)	
×	29b. Signature and title of certifier 29c. License number		29d. Date signe	d (Month, Day, Year)	-
	Mundle ma nazzus		7/1	199	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	-	1/1/	//	
	200 - 2	HEMI R	2.14 1	1 2 0	
Chala	31. Date filed (Month, Day, Year) 32 Registrar's Signature	430/10	4 1601 10	12/2/1	_
State Registrar	31. Date filed (Month, Day, Year)  JUL 0 2 1999  32. Registrar's Signature  Sports	450/,13	alto, p	12,21218	

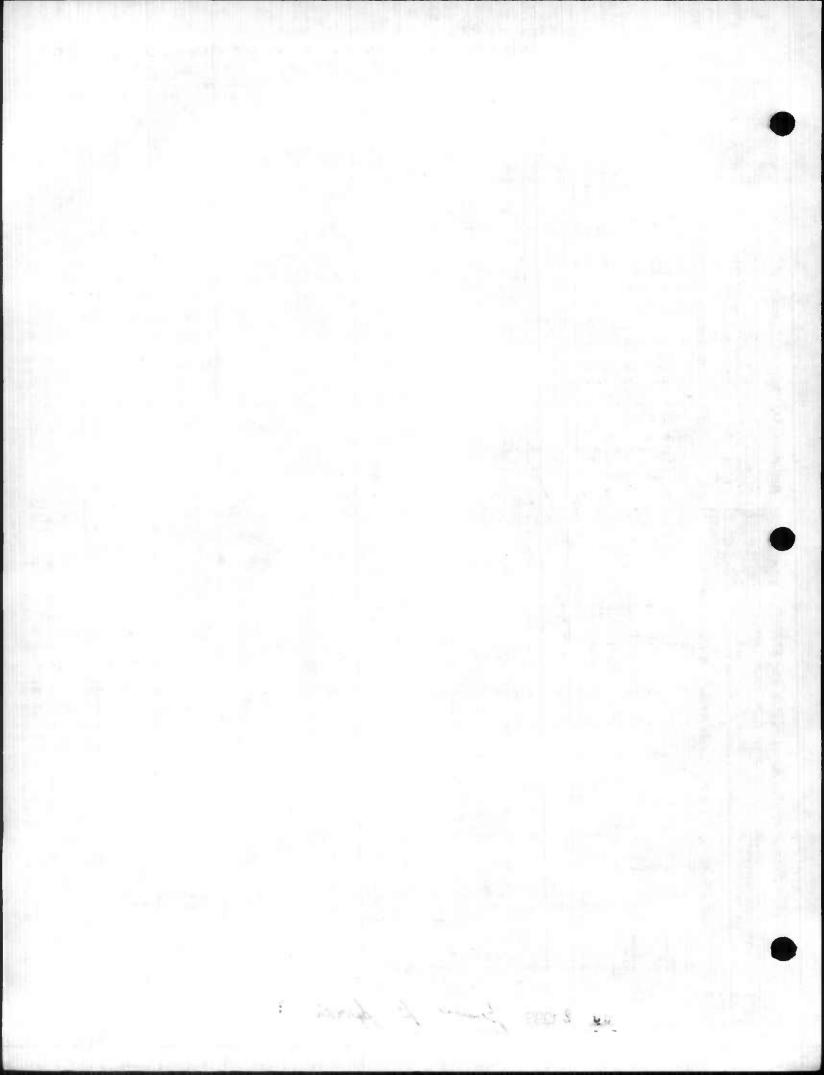
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State of Maryland / Department of Health and Mental Hygien 9 2 1 0 3 2

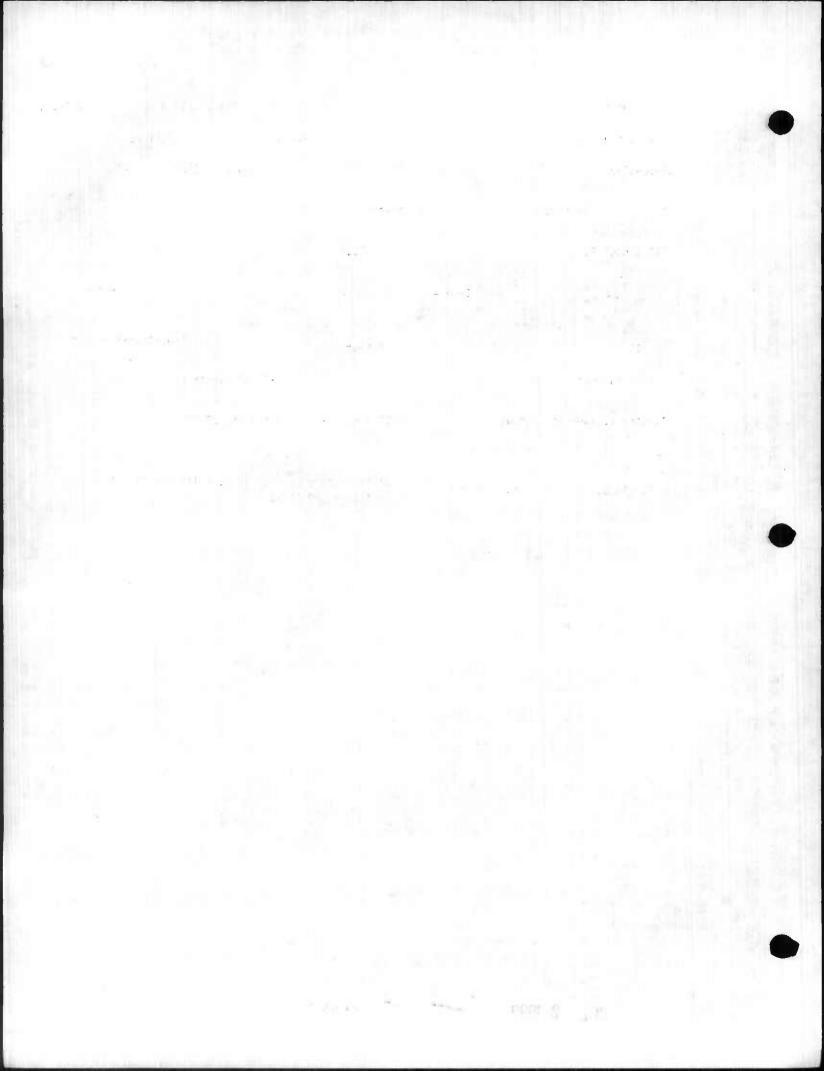
			Ce	rtificate of	Death		Reg. No.			
	1. Decedent's Neme (First, Middle, L	ast)				2. Date of De		140.00	3. Time of Death	
Physician	Yvonne Ka	therine Ko.	rmann			Juen	28°, 19	999	5:05 am	
/Medical Examiner	4a Facility Name (If not institution, gi	ve street end number)			4b. City, Town,	or Location of Deat	h 4c. County	of Death		
Examine	St. Agnes Re	habilitatio	n Cent	er	Fllico	tt City	Howa			
			s. last birthday		the state of the s				· (Chate on Fouri	
Funeral	Months Days Hours Min. (Month, Day,							9. Birthplace (State or Fay, Year) 25,1930 Marylan		
Director	210.20.3003	A	69			April	25,19	30 Mai	ryland	
	Usual Residence of Decedent  10e. State 10b. County	100 (	City, Town or L	ocation				104	Inside City Limit	
of a P								100.		
oto die	Maryland How	ard E	llicot	t City					1 Yes 2 N	
a or 25s-f show be notified at Director	10e. Street and Number			10f. Zip Code		A 1	10g. Citizen of V	What Country's	7	
iner mat b	10301 Spruce	IAT = Y		210	42-162	0	TT C	5.A.		
iloer mast Funeral	11. Marital Status	12. Was Decedent Ever in	U,S. 13.			(Specify Yes or No uerto Rican, etc.)		e - American		
5 B	1 Never Merried 2 Married	Armed Forces? 1 ☐ Yes 2 X No			an, Mexican, Pl	uerto Hican, etc.)	Blac	k, White, etc.		
Exami	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Detes:		1 Yes 2 No	Specify:		Specify	· Wh	nite	
	15. Decedent's E	ducation	16a Dece	dent's Usual Occur	nation		16b. Kind of Bu	isinges/Indust	try	
t, the Medical Completed	(Specify only highest gi		(Give	dent's Usuel Occup kind of work done DO NOT use retire	during most of	working	TOD. TURKS OF DE	Jan roga n ruu a	",	
The Man	Elementery/Secondary (0-12)	College (1-4or 5+)			0)		Public School			
		4	Edu	cator					1001	
dod eve	17. Father's Name (First, Middle, Las					Name (First, Middle		10)		
To The	Frank Korman	n			M	linnie				
	19e. Informent's Neme/Relationship	(Type, Print)	19b. Meil	ing Address (Street	and Number or	Rural Route Numb	er, City or Town,	State, Zip Co	de)	
22	Mignon Velie		103	01 Spru	ce Way	Ellico	tt City	, Md.	21042	
9 9	20e. Method of Disposition	20b.	Plece of Disp	osition (Name of metory or other place		Date	20c. Location -	City or Town,	Stete	
= 5	1 ☐ Burial 2 ☑ Cremetion 3 [	THemovel from Stete				7/1				
T S	4 Donetion '5 Other (Special	1 1		re-Wash			Laure]			
ny in	21. Signature of Famerel Service Lice	need /	2	2. Name end Addre	ss of Facility S	sterling	-AShtor	n-Schv	vab F.H	
2 4 0	Mean m	Peter				Ave. Ca				
	23a. Pert1 Enter the disease or conshoot in heart failure. List only	nolicetions that caused the de	eth. Do not en	ter the mode of dvir	na. such es care	diac or respiretory a	rrest.	. Ac	proximete terval Between	
ding physician and se as the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	bDue to	(or es a conse	quence of):						
g physicia as the bu	Cause (Disease or injury that initiated events resulting in death) Last	C. Due lo	(or es a consec	quence of):						
		d								
detached for u	Port II Other electificant conditions	annih sina ta danth hut ant u		-4-4-4	on to Boat I	l age pid	A-4			
d by the atten etached for u Physician	Pert II. Other significant conditions	contributing to death but not re	esuiting in the L	underlying cause giv	en in Pert I.				e cause of death	
deta C						10	Yes ZUNo	3 Probab	ly 4 Unknow	
2 2								- At 101 -	a to a Total and	
page 2 should be det							an eutopsy omed?	availa	autopsy findings ble prior to	
hes by						-		of dea	letion of cause ith?	
page Com						10	Yes 2000	1 D Y	es 2 No	
o o o	25. Was case referred to medical				00.01					
irector, pag o Be Co	exeminer?	Hospitel:		- all post Oth		Death (Check only				
= H	1 Yes 2 No 27. Menner of Death	1 L Inpatient 2	☐ ER/Outpatie	UK 3FT DOV	4.b.L.Mursin	g Home 5 Resi				
ed in by the funeral	1 ☑ Neturel 5 ☐ Pending	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	Wor		28d. Describe	how injury occur	red		
d in by the funeration:	2 Accident Investigation			M t 🗆	Yes 2 No					
6	3 Suicide 6 Could not to determined	28e. Plece of Injury - At building, etc. (Spec	home, ferm, st	reet, fectory, office		28f. Location ( City or To	Street and Numb	er or Rural R	oute Number,	
G G			,,							
ia i	29e. Certifier 1 Certifying Pi	hyelclan: To the best of my kn	nowledge, deet	h occurred at the tir	ne, date and pla	ace, and due to the	cause(s) and ma	nner as state	od.	
completely filled	(Check only 2 Medical Example)	miner: On the basis of examinand menner steted.	netion and/or In	ivestigation, in my o	pinion, death o	ccurred at the time,	date end plece,	and due to the	e cause(s)	
completely filled in Medical Cert	29b. Signeture and title of certifier	0		29c. Licens	se number		29d. Date signe	d (Month. Des	(, Year)	
ō	111	11 / 11.		102	1.101		1/2	1/		
	clestry !	P Willux	mo	1259	175		6/4	199		
	30. Neme and address of person who									
	Chesley W. Yel	lott, M.D.	8492 B	Baltimor	e Nati	onal Pil	ke Elli	cott	City,	
State	31. Dete filed (Month, Day, Year)	32. Registrer's Sign		1					_	
	_			-	- / 0					



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State of Maryland / Department of Health and Mental Hygiene 99 2 1 0 3 3

Physician / Medical Examiner 4a F  Uneral Jirector 5. So o 65-4 o	Adam Kundratic	e street end number)  ex 7. Age (In yr. 6  TO. C  12. Wes Decedent Ever in Armed Forces? 1  Yes 2 No If Yas, Give 1953 Yeer or Detes:  ucalion de completed)	6 Yrs. City, Town or Balt	Location imore 10f. Zip Code 21234	4b. City, Town, or I Parkville If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey June 29,19	Dey 1999 4c. County of Baltimo			
/Medical A fam 27 is marked other than "natural", or items 23e or 28e-1 ellow any injury or other traumatic event, the most industrial and injury or other traumatic event, the most injury or other traumatic event,	Facility Name (If not institution, give 8711 School Road Social Security Number 6. Security Number 13-30-1233 11 Residence of Decedent 1. Stete 10b. County MD Baltimon 1. Street and Number 8711 School Road Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest grace ilementary/Secondary (0-12) 12  Fether's Name (First, Middle, Last) Adam Kundratic	7. Age (In yr. 6  10c. C  12. Wes Decedent Ever in Armed Forces? 1 🖄 Yes 2 🗎 No It Yas, Give 1953 Yeer or Detes:  ucalion de completed)	6 Yrs. City, Town or Balt	Location imore 10f. Zip Code 21234	Parkville If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey June 29,19	4c. County of Baltimo (, Year)	of Death  Pe  9. Birthplace (State or Fore Country)  PA  10d. Inside City Lim		
incorporate form worker than 28 or 28 of 2	8711 School Road Social Security Number 13-30-1233  Juli Residence of Decedent 1. Stete 10b. County MD Baltimor  8711 School Road  Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  (Specify only highest gradiementary/Secondary (0-12) 12  Fether's Name (First, Middle, Last) Adam Kundratic	7. Age (In yr. 6  10c. C  12. Wes Decedent Ever in Armed Forces? 1 🖄 Yes 2 🗎 No It Yas, Give 1953 Yeer or Detes:  ucalion de completed)	6 Yrs. City, Town or Balt	Location imore 10f. Zip Code 21234	Parkville If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey June 29,19	Baltimo () Year) 933	9. Birthplace (State or Fore Country) PA		
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	Adam Kundratic	College (1-4or 5+)	life	Artist	daning most of wor	King	Education	-Research		
					18. Mother's Nen	ne (First, Middle, i	Meiden Sumeme	)		
					Ella	Elizabeth	izabeth Frick			
	a. Informant's Name/Relationship (T	'voe Print)	19h 14e	ailing Address /Street	and Number or Di	iral Route Numbe	r. City or Town S	ity or Town, State, Zip Code)		
								nate, Esp 0000)		
	Dorothy V. Kundration			711 School R	oad, Baitin			City or Town, State		
	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, c	remetory or other ple	ce)	Date	Zoo. Education - C	ny or rown, State		
23a.	Signature of Funeral Service Licens Ronald S. Wade, D			22. Name and Addre State Anato Baltimore,	my Board, 6	555 W. Balf	timore Str	eet		
E Unat	quentially list conditions, ny, leading to immediate usa. Enter Underlying use (Disease or Injury t initiated events ulting in death) Last	b. Reno								
0 6 5		d								
	II. Other eignificant conditions co	entributing to death but not re	esulting in the	underlying cause of	ven in Pert I	23b. Did tobacco use contribute to the cau				
be detached for use by Physician/		Weber Re				1 U Y	1	3 Probably 4 Unk		
2 should	Corono			isease		24a. Was a perior	in autopsy med?	24b. Were autopsy findin available prior to completion of cause of death?		
Com Com						1/Z/Y	es 2 No	1 ☐ Yes 2 Ø No		
	Was case referred to medical axaminer?	11 5 1				ath (Check only or	10)			
5 5 1	Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Tima	of 28c. Injury	y al rk?		ence 6 Other			
3 3 3	2 Accident 3 Suicide 6 Could not be determined		home, farm, cify)		1 Yes 2 No  28f. Location (Street end Number or Rurel R City or Town, State)			r or Rurel Route Number,		
Pletsly fills  edical C	. Certifier NZ Certifying Phy	velcian: To the best of my kniner: On the basis of examinand manner stated.	nowledge, de netion and/or	ath occurred at the til investigation, in my o	ne, date end piace pinion, death occu	, and due to the c rred et the time, c	ause(s) and man late end place, er	ner as stated. nd due to the cause(s)		
± € 29b.	(Check only 2 Medical Exami			29c. Licens	e number		29d Date sinned	(Month, Dey, Year)		
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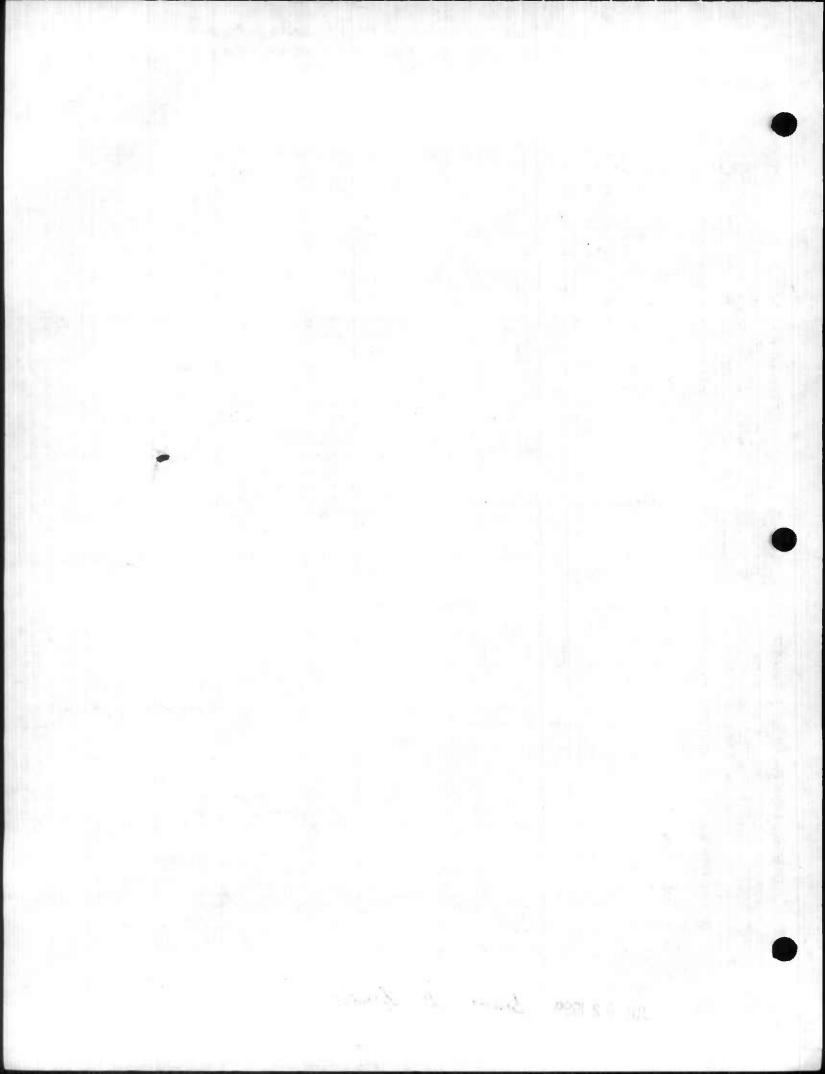


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State of Maryland / Departme

rtificate of Death Reg. No.	J	7	6	1	U	J	L
artment of Health and Mental Hygiene	0	0	0	1	0	0	1

Lloyd	Certificate of Death Reg. No. 99 210									1034		
	1. Decedent's Name (First, Middle, La	st)					2. Dete of C	eath		3. Time of Death		
Physician /Medical	Ronald Charl	les Lloyd					Month June	Dey 28 1	Yeer L999	10:05 AM.		
Examiner	4e Facility Neme (If not institution, giv	a street and number)					or Location of Dec		The state of the s			
		23 Garden A				Balti			Ltimor	e		
Funeral Director	218-44-0911	Sex 7. Age (	(In yrs. last birth	rs. If Under Months	1 Year Deys	If Under 24 H Hours Mi	in. 8. Dete of 8 (Month, I	16, 1943	9. Birthplac Country Mari	ce (State or Foreign Yland		
D	Usual Residence of Decedent  10a. Stete 10b. County	1	IOc. City, Town	or Location					100	I. Inside City Limits		
vith the Maryt t or 25a-f sho be notified at Director	Maryland Baltimo			Bal	timo	re				1 ☐ Yes 2 ☐ No		
	10e. Street and Number 3123 Garden Au	renue		10f. Zip	212	234		10g. Citizen of V		n		
Dy P	11. Marital Stetus  1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	er in U,S.	13. Was Decedif Yes, specific		lispanic Origin? en, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.  Specify: White				
5-0 72 ho	15. Decedent's Ec (Specify only highest gra	fucetion	16a. I	Decedent's Usua (Give kind of wo	ol Occup	pation during most of w	vorkina	16b. Kind of B	usiness/Indu	stry		
Ind 21215-0 be filed within 72 ho tal Hyglene. d other than hatter event, the Medical.  Be Completed	Elementery/Secondery (0-12)	College (1-4or 5+)				during most of w d)	ioning	Ctool	0			
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land ontal Hy and other c event,	17. Father's Name (First, Middle, Last)  John J. Lloyd					Marga		ahner	ne)			
T matter	19e. Informent's Neme/Reletionship (	Type Print)	19h	Mailing Address	(Street			ber, City or Town,	State Zin C	ode)		
and 2	Mrs. A. Margaret		her) 3	123 Gar	den		Baltimo	re, MD	21234			
altimore, mil. Pages 1 ar partment of Hea portant. If Item y Injury or other	20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donetion 5  Other (Specific		cemetery		ther ple	rtory	7/1/99	Baltimo				
Ball permit mport import any in	21. Signeture of Funerel Service Licer  Buan G	Willer	$\sim$	Schim 9705	d Addre Unek Belo	ess of Facility  Funera  Lir Rd.	l Home, Baltimo	Inc.	21236			
Medical Examiner site buffer and street buffer and street buffer and street buffer and street Examiner edical Examiner	Immediate Cause (Final disease or condition resulting in deeth)  Sequentially list conditions, if any, leading to immediate	b	ue to (or as e co	onsequence of):	rd	iovasi	ular 1	Disease	9			
2 2 5	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	c	ue to (or as e co	onsequence of);								
tha dee y the et sched fo	Pert tl. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.							23b. Did tobecco use contribute to the cause of deati				
								Yss 2XNo	3 Probe	bly 4 Unknown		
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The law site has by page 2 s							1	pection	of de			
VITAL idelan: The certificate rector, pe	25. Was case referred to medical					26 Place of C	Deeth (Check only	Yes 2010	10	Yes 2□ No		
OT VITA OT VITA Physician: this certific and director,	examiner? T☐ Yes 2☐ No	Hospital: 1 Inpatient	2□ER/Out	patient 3 DC	DA Oti	or.		sidence 6 Oth	ner (Specify)			
Ior After Ing	27. Menner of Deeth  1. Natural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Y	28b. Ti		8c. Inju Wo		- 44	how injury occur		1 0		
DIVISION C ball or Attending P is after death. al Director: Aftert ed in by the funers Certification:	3 Suicide 6 Could not by determined	28e. Plece of Injury building, etc. (	r - At home, ferr (Specify)	m, street, fectory	y, office			(Street and Numb own, State)	ber or Rural I	Route Number,		
To the Hospital or Attend within 24 hours after deat completely filled in by the Medical Certificat	29a. Certifier 1 Certifying Ph (Check only one) Company Control one)	ysician: To the best of r niner: On the basis of ex end menner stete	kaminetion and	deeth occurred /or investigation,	et the ti	me, date end pla opinion, deeth oc	ice, end due to the courred et the time	e cause(s) and ma e, date end place,	anner es stat and due to ti	led. he cause(s)		
To the complete	29b. Signeture end title of certifier			290	c. Licens	se number		29d. Date signe	d (Month, De	ay, Year)		
	Aturl.	AUL	cola	MD	0.0	M.E.	100	.Tur	ne 28,	1999		
7 11	30. Name and address of person who		- ' ' '	Type, Print)						also at all all		
	Stephen S. 31. Date flied (Month, Day, Year)	12 adent	Signatu F	enn Str	eet	, Baltim	ore, Mai	cyland 21	1201			
State Registrar	31. Date filed (Month, Day, Year)	Service	Signal .	pour								



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#18 perFH G773 7/2/99 EW Certificate of Death Beg No. 1. Decedant's Nama (First, Middla, Last) 3. Tima of Death 2. Data of Death Month JAMES LEWIS 1999 1:27 AM 4a Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death UNIVERSITY OF MARYLAND MED CTR. BALTIHORE If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, 5. Social Sacurity Number 6 Sax 7. Aga (In yrs. last birthday) 9. Birthpiaca (Stata or Foraign Country) Days 330-39-9370 Usual Rasidance of Decedant 1XM 2□ F Months JULY 04, 1928 VIRGINIA 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No BALTIMORE CIT MARYLAND 10e. Street and Number 10g. Citizan of What Country? 920 USA, 14. Race - American Indian, 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Dacedent Evar in U.S. 11. Marital Status Armed Forcas?

1 Yas 2 No
If Yas, Giva
Yaar or Datas: Black, Whita, atc. 1 Navar Married 2 Married 1 Yas 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedent's Education (Specify only highast grada completed) 16b. Kind of Bustnass/Industry Ejamantary/Secondary (0-12) Coltaga (1-4or 5+) ABORER 4+4 GRADE DOMESTIC WIPING CLOTH CO. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Justice HENDERSON LEWIS SR. NARCISSUS JUCTICE 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 920 BENNETT PLACE, BALTIHORE, MP, 2/223 e of Disposition (Nama of Date 20c. Location - City or Town, Stata KOSE DARDEN SISTERI 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 07-06-99 BALTIHORE HARYLAND 4 Donation 5 Other (Specify) ARBUTUS CEMETERY 22. Nama and Addrass of Facility 21. Signatu of Pynaral Sarvice Licensaa H. BROWN JR. FUNERAL HOME FULTONAVE, BALTO, MD, 2/2/ 19, such as cerdiac or respiratory afrast, Approximate JOSEPH 2140 N 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory shock, or heart failure. List only one cause on each line. Immediata Causa (Final 2 MO. LUNG CANCER disaasa or condition rasulting in daath) PNEUMONIA 2 WK Dua to (or as a consaquance of): Dua to (or as a consaquance of) 23b. Did tobacco use contribute to the cause of death? Part tt. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part t. 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to complation of ceusa of death? 24a. Was an autopsy

**Physician** /Medical Examiner

physician and s the burief-transit

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signed by the e

certificate her

this funeral

After

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The lew requires that the death certificate be executed

P.O. Box 68760.

Records,

Division of Vital

Hospital or Attending Physician:

death.

after deat Diractor:

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

Examiner

Physician/Medical

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ortant: If I

**Physician** 

/Medical

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**Funeral** 

Director

Peges 1 and 2 should be filed within 72 hours effer deeth with the Maryland nert of Heath and Mentel Hygiene.

nt: If flam 27 is marked other than "natural", or flams 23s or 28s-f show iry or other traumatic event, the Medical Examinations to a notified at

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated evants rasulting in death) Last

1 Yas 1 □ Yas 2 □ No 25. Was cesa rafarred to medicel axaminar? 26. Piaca of Death (Check only ona) axaminarr 1 ☐ Yas 2 No spital: 1 Inpatiant 2 ER/Outpatient 3 DOA
28a. Date of Injury
(Month, Day Year) 28b. Time of
Injury 28c. Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding

27. Manner of Daath Natural
Accidant 1 Yas invastigation 3 Suicida 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 26a. Place of fnjury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida

1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and due to the cause(s) and mennar as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to the ceusa(s) and mannar stated. 29a. Cartifias

29b. Signatura and titla of certitian

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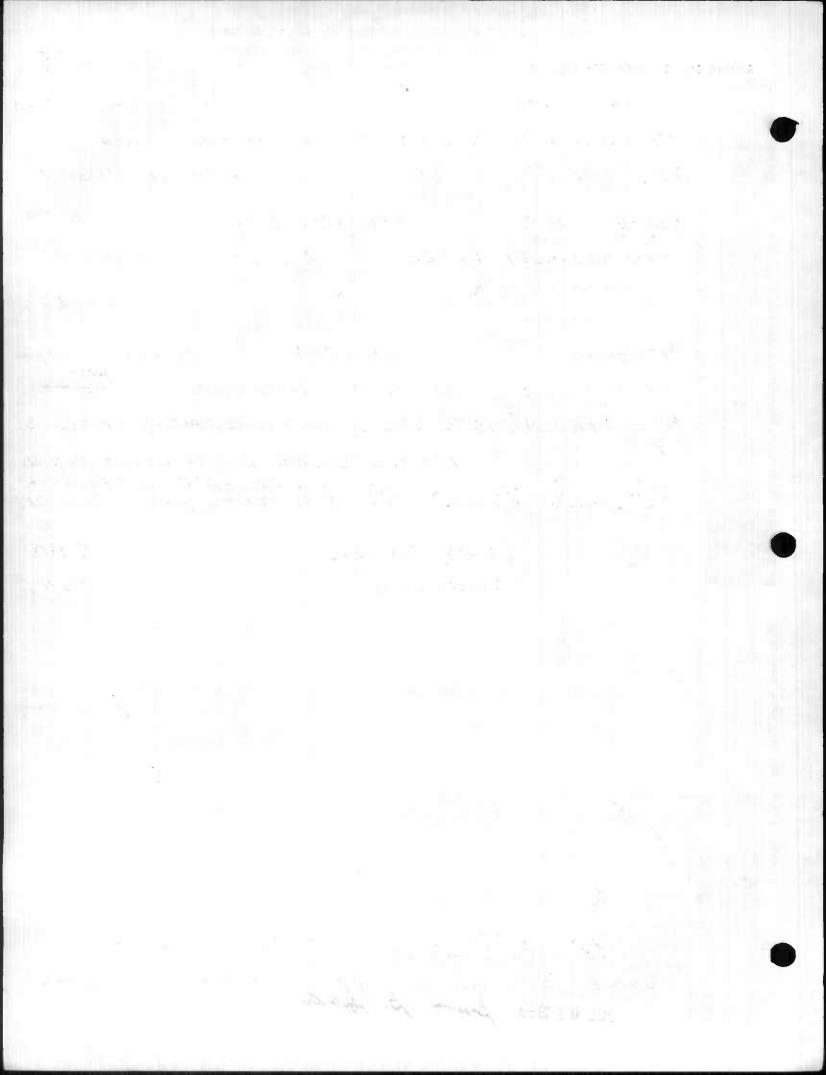
29c. Licansa number P10205

29d. Data signed (Month, Day, Year)

causa of death (itam 23a) (Type, Print) 30. Nama and addrass of person who comp

22 5 GREENE ST., BALTIMORE SCAVEUA 32. Registrar's Signatura 31. Data filad (Month, Day, Yaar)

State Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 21036 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 99 ERNARI HENDERSON EE 28 :45 AM JUNE 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death BALTI HORE If Under 24 Hrs. 8. Dale of Bir COLDSPRING LANE 8. Dale of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 219-18-8344 12 M 2 F Yrs. NOV. 20,1925 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No MARYLAND 10e. Street and Number 10g. Citizen of What Country? 09 39 21215 OLDSPRING 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2MNo 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Yes, Give BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 5 THGRADE DAVIDSON CHEMICAL CO, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) E ALICE DERNARD MOORE 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3909 W. COLDSPRING LANE 2 MP FL LEE LWIFE PFL BALTIMORE, NO. 21215 20c. Location - City or Town, State ORETTA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 18 Burial 2 Cremation 3 Removal from State DRUID RIDGE CEMETERY 07-02-99 PIKESVILLE, MARYLAND 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility BROWN JR. FUNERAL HOME TO SEPH H. BROWN JR. FUNERAL HOME rure of Funeral Se JOSEPH 2140 N. FULTON AVE. BALTIHORE MO. 21217 T. Enter the disease, or complications that caused fits ck, or heart failure. List only one cause on each line. eth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final COLON disease or condition resulting in deeth) METASTATIC CANLPR Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 201 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred

Box 68760, o ۵. Records, Division of Vital

signed by the a page 2 certificate

Physician/Medical

Completed by

Be

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Directo

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72 hours after

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marked other 7 is marked other traumatic event,

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permit. Pege Department of Important: If any Injury or

**Physician** /Medical

Examiner

21215-0020

Baitimore, Maryland

The law requires that the death certificate be executed or Attanding Physician: this Affer 24 hours after death.

Funerel Director: A

Hospital

within 2 \$ \$

Medical Certification: To in by 4 Homicide 29a. Certifier completely (Check only one)

1 Neturel

3 Suicide

2 ☐ Accident 6 Could not be determined

5 Pending investigation

28a. Date of Injury (Month, Day Year)

28b. Time of Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury al Work? 1 Yes 2 No

Location (Street and Number or Rural Route Number, City or Town, State)

🗠 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

6.W.D

D0053467

29d. Date signed (Month, Day, Year) 30

30. Name all add less of berson who completed cause of death (Item 23a) (Type, Print)

MERCHANT 31. Date filed (Month, Day, Year)

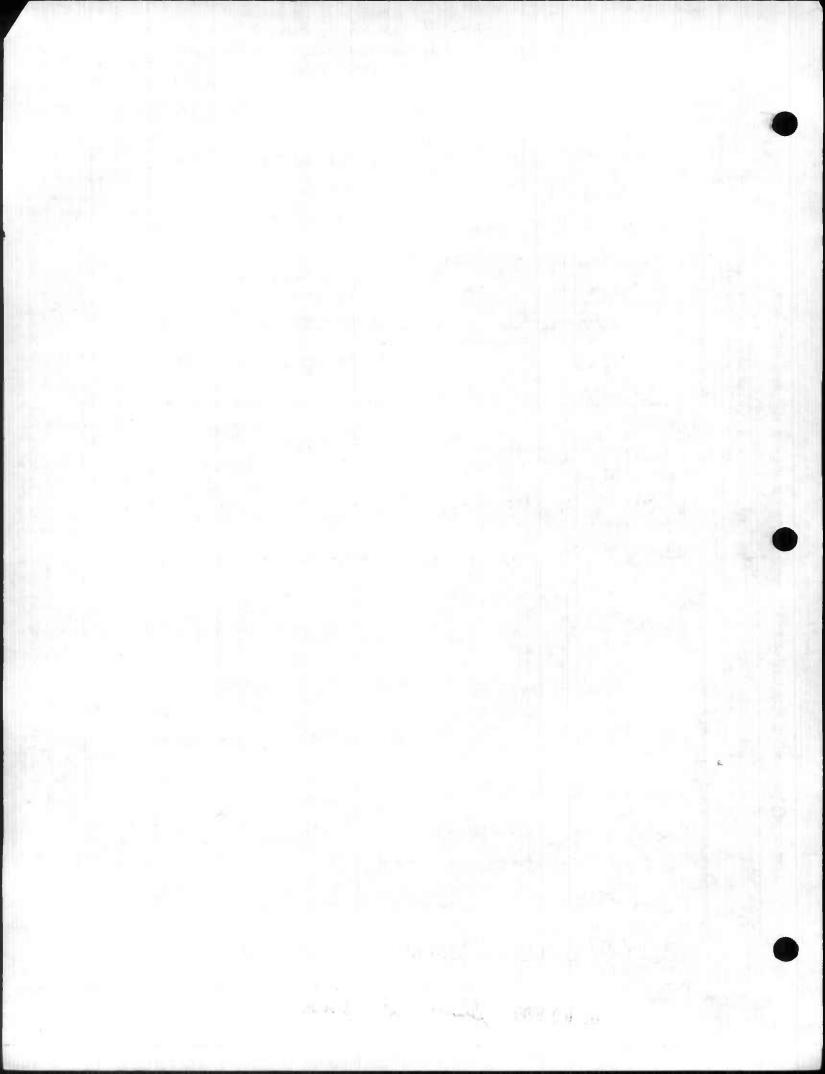
SINAI 32. Registrar's Signature

HOSPITAL 2435 W. BELVEDERE

BALTIMORE AVE

MD 21215

State Registrar



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		Decedent's Nama (First, Middle)	Last)		Certificate					eg. No.		3. Time of Death
	Physician		Last							Day 27, 199	Yaar	8:00 PM
	/Medical	Martin Lennig  4a Facility Nama (If not institution,	give street and number)			1.	4b. City, To	wn, or Loc	ation of Death	4c. County		
	Examiner	11880 Homewood					E1	1ico	tt City			
F	uneral		6. Sex 7. Ag	e (In yrs. last birt	hday) If Under		If Under:	-	8. Data of Birth (Month, Day,			placa (State or Foreign
	irector	100-16-6829	10XM 20 F	76	frs. Months	Days	Hours	Min.	Oct. 22	, 1922		York
pu		Usual Residence of Decedent  10a, Stata  10b, County		10c. City, Town	or Location							0d. Inside City Limits
Amyle	of a po		ard									1 ☐ Yas 2 ₺ No
ğ	or 28a-fall be notified Director	10e. Street and Number	alu	00	olumbia	Code			1	0g. Citizen of V	Vhat Cour	ntry?
N C	therns 23s or 28s-f show free must be notified at Tuneral Director	5029 Green M	lountain Cir	cle	23	1044				U.S.A.		
deat	r Nome 23a	11. Marital Status	12. Was Decedenl Armed Forcas?	Evar in U,S.	13. Was Decede	ent of H	lispanic Orig	gin? (Spec		14. Race	e - Americ k, White,	an Indian,
1215-0020 within 72 hours after death with the Maryland	五里	1 Nevar Married 2 Marrie			1 ☐ Yas 2			i, ruano n	tioari, etto.	100	: Wh:	
Nours	natural, or	3 ☑ Widowed 4 □ Divorced	Year or Datas:						1			
15-		15. Decedent's (Specify only highest	grade completed)	16a.	Decedent's Usual (Give kind of work life. DO NOT use	k done e retire	ation during most	t of workin	g	16b. Kind of Bu	sinass/in	dustry
212 E	Comp	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Electric					General	F100	tric
	2 0	17. Father's Nama (First, Middle, L	ast)		21000110				(First, Middle, I			CLIC
yian Vente be	To B	Emil Lennig						Alic	e Gard	iner		
laryia	7 is marks traumatic TO	19a. Informant's Name/Ralationsh	ip (Type, Print)	19b.	Mailing Addrass	(Street	and Numbe	er or Rural	Route Number	City or Town,	State, Zip	Code)
gire orași	n 27 i	Dorothy Lennig	(Daughter)	1	1880 Hom	iewo	od Dr	ive,	Ellicot	t City	. MD	21042
Pages 1	0	20a. Mathod of Disposition  1 Burial 2 Gremation	3 □Removal from Stala		Disposition (Namy, crematory or other				1	20c. Location -		
Baltimore,	lury or	4 ☐ Donation 5 ☐ Other (Sp.	ecify)	Balto.	Washing	gton	Crem	. 6	30 99L	aurel,	Mary:	land
Bal	ny in	21. Signature of Funeral Service U	garge ()		22. Nama and			w <sub>1</sub>	tzke Fu			s, Inc.
0.0	2 4 0	00000	X EU						oad, Col		MD	21045
		23a. Part1. Entar the disease, or o shock, or haart failure. List of	omplications that caused nly ona cause on each li	I tha death. Do n na.	ot entar tha moda	of dyir	ng, such as	cardiac or	raspiratory arr	ast,	1	Approximata Intarval Batween Onsat and Death
	sician ledical	Immediate Cause (Final	C. 1.	. 1			Λ	1			1	· (
	miner	disease or condition resulting in death)	· Cardi			4	Hire!	ST			1	minutes
	ğ		N - 1	Due to (or as a c	onsequance of		1/0-	D.A. 4				.7
Petho	in and hel-transit Examiner	Sequentially list conditions	. Nont	Due to (or as a c	onsequence of):	yn	Aprio	me			1	ozgeavi.
68760, ificate be execut	physician and the burial-transit edical Examir	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury				1	•				1	7
68760, ficate be ex	physicies the burner and call	that initiated events resulting in death) Last	С	Due to (or as a c	onsequance of):						1	
	Mec		d									
Geath cen	for us		_ 0									
P.O.	signed by the attending d be detached for use a d by Physician/Me	Part II. Other significant condition	s contributing to death be	ut not rasulting In	tha undarlying ca	usa giv	ren in Part I.					the cause of death?
	deta y								1 🗆 Y	88 2□ No	3 Pro	bably 40 Unknown
ords, P.O	og p								24a. Was a	n autopsy	24b. W	ara autopsy findings
0 5	ga 2 should to mpleted ?								perform	ned?	co	ailable prior to mplation of cause death?
I Rec	page 2 should Completed								1 U Y	s 2 No		☐ Yas 2☐ No
	director, paga for Be Com	25. Was casa referred to medical		-			26. Placa	of Death	(Check only on		1	3 100 23 100
of Vital Records, Physician: The law requires the		axaminer? 1 ☐ Yes 2 No	Hospital: 1 Inpalie	enl 2 ER/Out	patient 3 DO/	A Oth	or:		a 5 Raside	.1	ar (Specil	n Doughters
0 4	After this funeral di	27. Mannar of Death 1 Natural 5 ☐ Pending	28a. Data of Inju (Month, Da		ima of 28	Bc. Injur	y at k?	2	8d. Dascribe ho	w injury occur	ed	How
Vision Attending or death.	or: At	Accident invastige	ition		М		Yas 2□I	No				
Division  or Attanding after death.	al Director: After to led in by the funeral Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide detarmin	28a. Place of Inju-		m, street, factory,	office		2	81. Location (St City or Town	reet and Numb n, Stata)	er or Rura	al Route Number,
O jest	D D O	CO Codding and Co and I										
Div To the Hospital or within 24 hours afte	To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one)  Certifying  Certifying  Description	Physician: To the best of taminer: On the basis of and manner sta	axamination and	death occurred a Vor invastigation, i	t tha tir in my o	na, data and pinion, daat	d place, ar th occurre	nd dua to the ca d at Iha tima, d	ausa(s) and ma ata and place, a	nnar as s and dua l	tated. o the cause(s)
o the	ompi	29b. Signature and titla of certifier	10		29c.	Licens	e number		2	9d. Date signe	(Month,	Day, Year)
- 3	P- 0	Muchia 0	Then 1	D.		n	004	171	65	6/	30/	99
		39. Name and addrass of person w	ho completed causa of d	eath (Item 23a) (	Type, Print).	2	-	.0	11	0/	1	
		Michael K. Gir	WER M.D.	1000 N	. WOLF	St	top	ta	Ito. M	W ?	428	
	State	31. Data filed (Month, Day, Year)	32. Registra	ar's Signatura	/	-						
	Registrar	JUL 2 10	99 Gener	a B.	Sport	6						
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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 2 1 0 3 8

			Ce	ertificate	e of E	Death	Re	ig. No.	21030
Physician	Decedent's Name (First, Middle, L IRVING	L.		MA	LESO	1	JUNE 30	_	Year 3. Time of Dec 5:30 PM
/Medical Examiner	4a Facility Name (If not institution, g		G HOME		41	LUTHER	Location of Death	4c. County	of Death
uneral irector	5. Social Security Number 6. 214-03-7299		n yrs. last birthday 87 Yrs.	) If Under Months	1 Year Days	If Under 24 Hr Hours Min	s. 8. Date of Birth		Birthplace (State or For Country)     PA
show sd.at	Usual Residence of Decedent  10a. State  10b. County	10	Oc. City, Town or L						10d. toside City L
be notified at Director	MD N/A  10e. Street and Number	- #330	BALTIMOF	RE 10f. Zip	Code	01015	10	Og. Citizen of V	What Country?
Examiner must by Funeral I		12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	or in U,S. 13.	Was Deced If Yes, spec		21215 spanic Origin? (s, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		e - American Indian, ck, White, etc.
r, the Medical Completed	15. Decedent's E (Specify only highest g		(Giv	edent's Usua e kind of wor DO NOT us ESMAN	al Occupa rk done di se retired)	tion uring most of w	orking	16b. Kind of Bu	usiness/Industry
inted other atte event, I To Be Co	17. Father's Name (First, Middle, Las	0	MALESO			18. Mother's Na	ame (First, Middle, N		
27 is married or traumant	19a. Informant's Name/Relationship HOWARD S. MALES						Rural Route Number, ONIUM, MD		State, Zip Code)
or other	20a. Method of Disposition  1  Burial 2  Cremation 3   4  Donation 5  Other (Spec	Removal from Stata	20b. Place of Disp cemetery, cre HAR ZION	ematory or of	ther place				City or Town, State
Important: any injury 2028.	21. Signature of Funeral Service Line		1 2	22. Name and	d Address	of Facility	SOL LEVI	NSON &	BROS., INC. LE, MD 21208
vsician ledical aminer	23a. Part1. Enter the disease, or conshock, or heart failure. List only the second sec	Pne	UMOnt conse	<u> </u>					Approximate Interval Betwee Onset and Dea
nding physician and use as the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or influry that initiated events resulting in death) Last	c	o to (or as a conse						
igned by the attending be detached for use by Physician/M	Part II. Other significant conditions	contributing to death but n	ot resulting in the	underlying ca	ause give	n in Part I.	23b. Dld tol	bacco une cor	ntribute to the cause of d
\$ A							1 🗆 Ye	a 2 No	3 Probably 4 Luni
page 2 should a				1			24a. Was ar perform	n autopsy ned?	24b. Were autopsy findi available prior to completion of caus of death?
s certificate had director, page	25. Was case referred to medical					26. Place of D	1 ☐ Ye	s 2 100	1 ☐ Yes 2 ☐ No
: After this ce funeral direct ation: To E	axaminer? 1	28a. Date of Injury (Month, Day Ye	2 ER/Outpatie		8c. Injury Work	4 En Nursing	Home 5 Reside		
To the Funeral Director: After the completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not determined		At home, farm, s Specify)	treet, factory	, office		28f. Location (Str. City or Town	reet and Numb , State)	er or Rural Route Number
To the Funeral completely filled Medical C	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the best of m miner: On the basis of exa and manner stated.	amination and/or is	th occurred anvestigation,	at the time in my opi	e, date and place nion, death occ	e, and due to the ca curred at the time, da	use(s) and ma ite and place,	nner as stated. and due to the cause(s)
Toth	290. Signature and title of certifier	Kelle	2) mo		License		29	Od. Date signed	d (Month, Day, Year)
	30. Name and address of person who Elliot Rothsch	completed cause of death	(Item 23a) (Type	Print)	Pik	esuitle	mo a	1208	,
State Registrar	31. Date liled (Month, Day, Year)	2 32 Registrar's		-					

mer \$ 10

### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Data of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) Month Physician 1999 10 HM JUNB James E. Mencil 4a Facility Nama (If not institution, giva street and number) /Medical 40 County of Death 4b. City, Town, or Location of Death Examiner If Under 24 Hs. 8. Data of Birth (Month, Day, Year) STELLA MARIS @ MERCY 9. Birthplace (Stata or Foreign Country) If Undar 1 Yaar 7. Aga (In yrs. last birthday) **Funeral** 1₩ 2□ F Months Days Yrs. 52 07-28-46 S.C Director 247 72 3026 Usual Residence of Decedent 10a Sfeta 10h. County 10c. City. Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f ahov other traumatic event, the Madical Example or must be notified at 1 XXas 2 □ No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Funeral 1330 LAURENS STREET 21217 13. Was Decedant of Hispanic Origin? (Specify Yas or NoIf Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) 14. Race - American Indian, 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ঐ No If Yas, Giva Yaar or Datas: permit. Pages 1 and 2 should be filed within 72 hours effer c Department of Hasilth and Mental Hygiena. Important: if Itam 27 is marked other than "natural", or item any injury or other traumatic event, its Med at Event Black, Whita, atc. 1 Navar Marriad 2 Married 1 Yas 2 No Specify: Specify: BLACK PV 3 Widowad 4 Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elamantary/Secondary (0-12) Collega (1-4or 5+) ORDERLY HEALTH 18. Mothar's Nama (First, Middla, Melden Sumema) 17. Fathar's Nema (First, Middle, Last) Be JOSEPH MENCIL, SR. GLADYS LEAF 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Ralationship (Type, Print) JANICE E. MALLORY/DAUGHTER 65 MILLET ST. DORCHESTER, MA 02124 20b. Plece of Disposition (Nama of cemetary, cramatory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stafa Data XXBuriat 2 Cramation 3 Ramoval from Stata Donetion 5 ☐ Other (Specify) Druid Ridge Cem. 7/2/99 Balto., 22. Nada sad Address of Facility Sons F.H., INC 7/2/99 Balto., Md. 21 Signatura of Funaral Sarvice Licensee 1701 LAURENS ST. BALTIMORE, MD. 21217 234 July Enfer the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Final Conver disaasa or condition rasulting in daath) **Examiner** Dua to (or as a consequence of): Examiner physicien end the buriel-transit Sequantially list conditions, if any, leading to immediata ceuse. Enter Underlying Causa (Disaasa or Injury that initieted avants rasulting in death) Last Dua to (or as a consequence of) Physician/Medical Dua to (or as a consaquance of): 65 60 attending USB 0 Pert fl. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? the bed 1 yes 2 No 3 Probably 4 Unknown 2 signed I py 24b. Wara autopsy findings available prior to 24a. Was an autopsy Completed complation of causa of daafh? paga 2 hes 1 Yas 2 No 1 Yas 2 No cartificeta 26. Place of Death (Check only one Stella MAris At Mercy Hospital or Attending Physician: 24 hours eftar deeth. Funeral Director: Aftar this carific funeral director, Be 25. Was case rafarred to medicel axaminar? Other: 4 Nursing Home 5 Residence 6 Other (Specify) No 1 Yas 2 No 2 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. fnjury et Work? 27. Mapmer of Deeth 28b. Tima of Certification: Netural 5 Pending 1 ☐ Yes 2 ☐ No invastigation 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Spacify) 4 Homloide 24 hours e 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, end due to the ceuse(s) end menner as stated. Medical Examiner: On the bast of axaminetion and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. edicai 29a. Certifier To the Hosp within 24 ho To the Fune complately fi (Check only one)

that the death certificate be Division of Vital Records.

Box 68760.

tha Meryland

Maryland 21215-0020

Baltimore,

State Registrar

31. Data filad Mo

29b. Signature and fitla of certifiar

Custon 301 32. Registrar's Signatura

30. Name and address of person who complated ceusa of death (Itam 23a) (Type, Print)

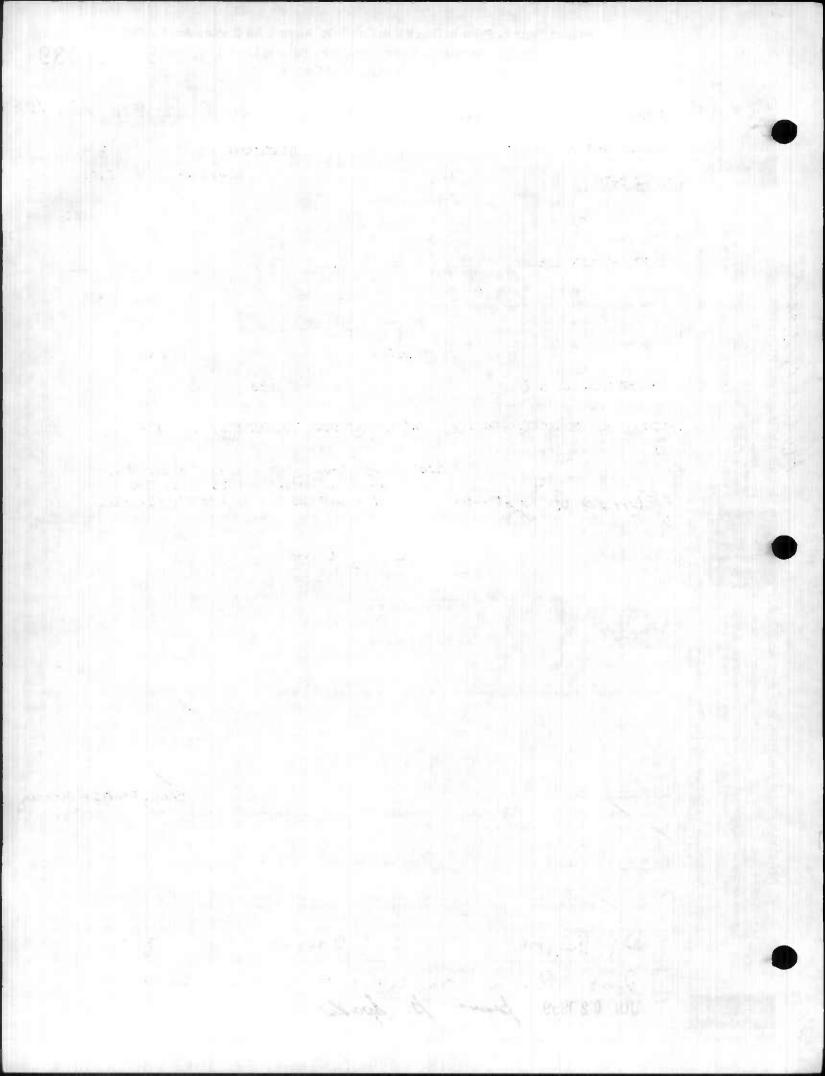
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29c. Licansa number D40854

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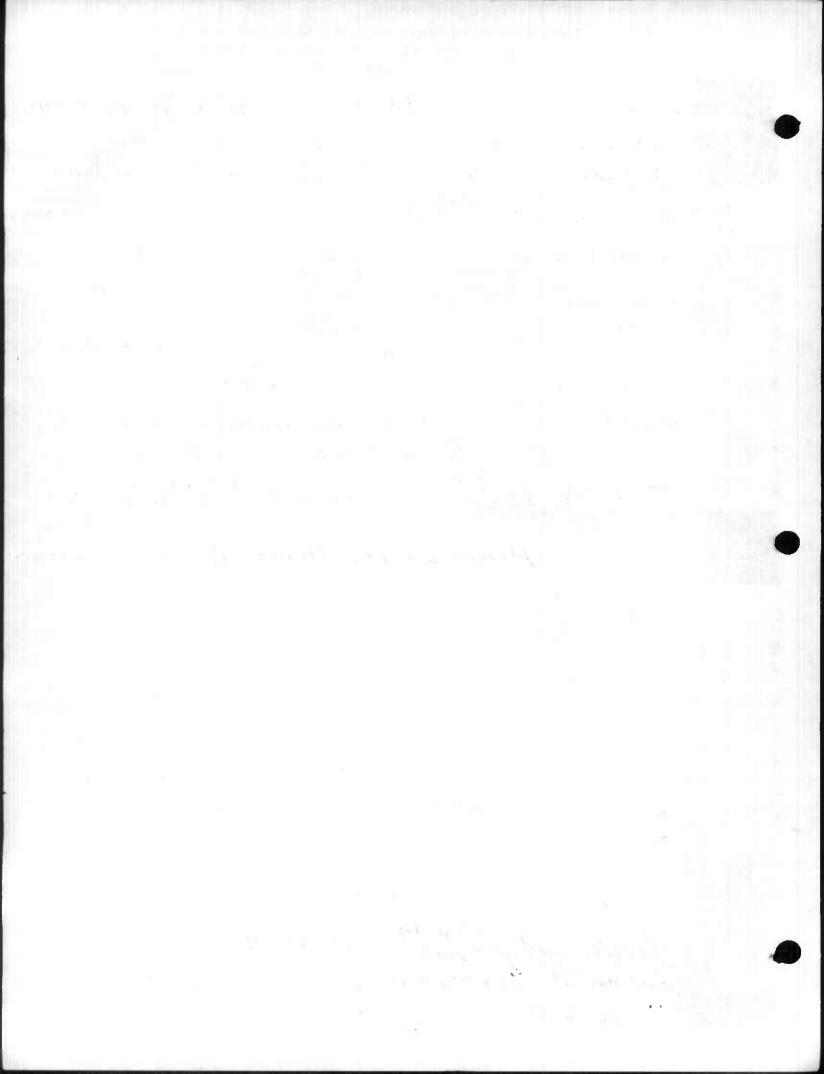
29d. Data signed (Month, Day, Year)

19



**DHMH 16 Rav 6/95** 

JUL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth JUNE 30, RAE PREISSMAN 1999 10:00 AM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death 7211 PARK HEIGHTS AVENUE #304 BALTIMORE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Dele of Birth (Month, Day, Year) JUNE 15,1916 5. Sociel Security Number 7. Age (In yrs. last birthday) Days 10 M 20 F Months Hours 83 Yrs. 215-01-2073 MD Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Vas 2 No MD N/A BALTIMORE 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 7211 PARK HEIGHTS AVENUE #304 21215 U.S.A. Was Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, 12. Was Decedent Ever In U,S Armed Forcas? 11 Merital Status Black, White, etc. I ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yas 2 ☑ No Specify: Specify. WHITE 3 ☐ Widowed 4 ☐ Divorced Yeer or Deles 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 HOUSEWIFE OWN HOME 17. Father's Neme (First, Middle, Last) 18 Mother's Neme (First Middle Maiden Sumeme) ELI SIMPSON SARAH 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e, Informent's Neme/Reletionship (Type, Print) BENAMIN PREISSMAN / HUSBAND 7211 PARK HEIGHTS AVE. #304 - BALTIMORE, MD 21215 20b. Plece of Disposition (Neme of cematery, crametory or other plece) 20e. Malhod of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) ARLINGTON CHIZUK AMUNO 7/2/99 BALTIMORE, MD 21. Signeture of Fundral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, earl tellure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immedieta Cause (Final disease or condition resulting in deeth) Due to (or as e consequence of) Sequentially list conditions, if any, leading to immediale cause. Enler Underlying Ceuse (Diseese or injury thal Initieted avents resulting in death) Lest Due to (or es a consequence of). Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to complation of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 1 ☐ Yas 26. Place of Deeth (Check only one) Hospitel: Other: 4 ☐ Nursing Home 5 ☐ Nursing Home 6 ☐ Other (Specify) 1 Inpalient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending invastigation 1 ☐ Yes 2 ☐ No

The law requires that the death certificate be executed and Box 68760. physician the for use as P.0. Division of Vital Records, page 2 should certificate or Attending Physician: funeral director, After this within 24 hours after death. To the Funeral Director: A

Examiner Completed by Physician/Medical Be filled in by the

**Physician** 

/Medical

Examiner

Funeral Director

à

Completed

88

**Funeral** 

Director

28a-f

r herra 23a or i

Pages 1 and 2 should be filed within 72 hours after their of Health and Mental Hyplano. sett if them 27 is marked other than "natural, or its ury or other traumetic event, the Medical Examines

**Physician** /Medical

Examiner

with the Maryland

21215-0020

Baltimore, Maryland

Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 25. Was case reterred to medical examiner? 1 Yes 2 No Certification: To 27. Manner of Death 2 Accident 6 ☐ Could not be delemined 28e. Plece of Injury - Al home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 4 ☐ Homicide 29e. Certifier edical Excertifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signeture and title of certifiar 29c. License number

**DHMH 16 Rev 6/95** 

Hospital

4

State Registrar

31. Date tiled (Month, Day, Year)

Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print) 1838 GREENE IREE RO 32. Registrar's Signeture

SACTIMORE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 39, 1999 3412 Joseph T. Papparotto 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore N/A If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

July 17, 1913 6. Sex 1 Ø M 2 ☐ F If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 85 Yrs. Maryland 212-07-3915 Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4765 Homesdale Avenue 21206 U. S. A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Westvaco 9th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Giovanni Papparotto Philomenia Granello 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9208 Nottingwood Road, Baltimore, Maryland 21237 Joseph J. Papparotto (Son) 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State t ⊠ Burial 2 □ Cremation 3 □ Removal from State Most Holy Redeemer 7/3/99 4 □ Donation 5 □ Other (Specify) Baltimore. Maryland 22. Name and Address of Facility
Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee Buan Ce. 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bowel perfo Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Description 2 ER/Outpatient 3 DOA 1 Yes No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, tactory, offica building, etc. (Specify) 4 Homicide

Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

MY cson who completed cause of death (Item 23a) (Type, Print)

> PONEFEE 2. Registrar's Signatur

29c. License number

044944

I calcut sme J Baltimore

29d. Date signed (Month, Day, Year)

**Physician** /Medical Examiner Papp aroth Toseph Hospital or Attending Physicien: .s efter de. To the Hospital or within 24 hours eff To the Funeral Di completely filled in

> State Registrar

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

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Completed

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Physician/Medical

by

Completed

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Certification: To

Medical

29a, Certifier

29b. Signature and title of g

physician and the buriel-transit

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director,

**Funeral** 

Director

Examiner must be

natural, or

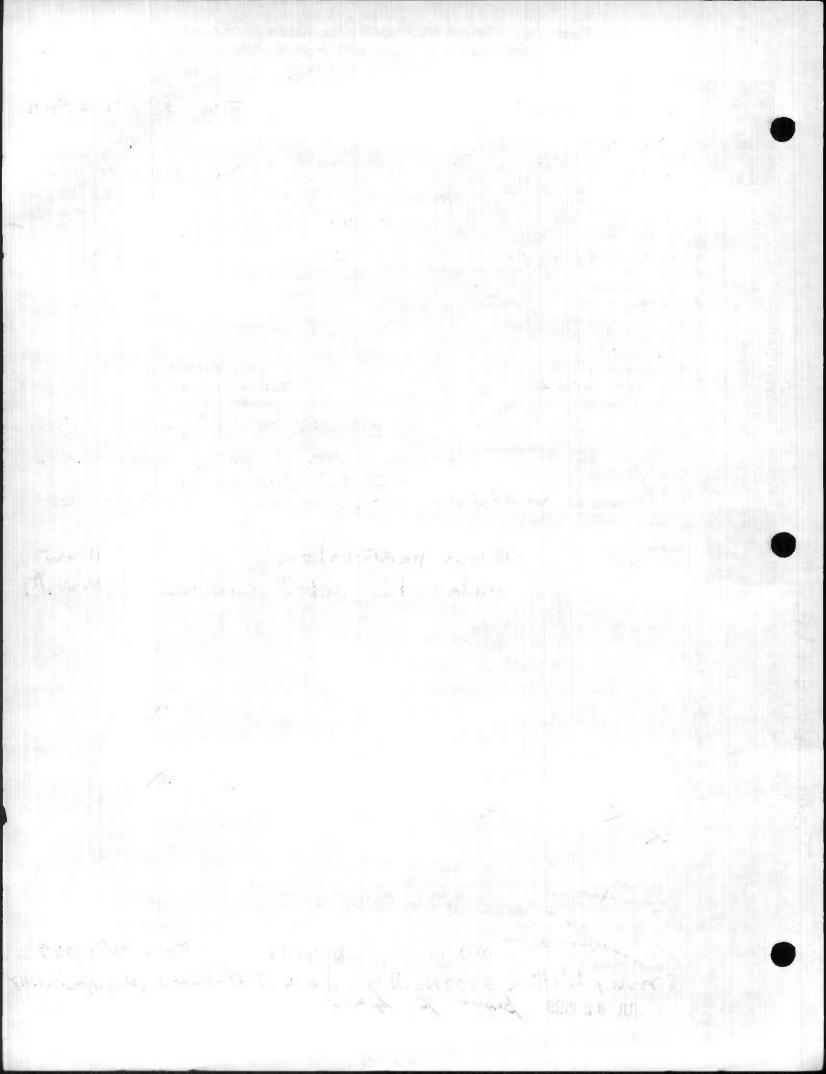
Peges 1 end 2 should be filed within 72 ho nent of Health end Mental Hygiene. Int: If Item 27 is marked other than "naturury or other treumatic event, tre Mexical any or other treumatic event, tre

permit. Peges 1 and 2 Department of Health er Important: If Item 27 is any injury or other treu

the Maryland r 28a-f show

with

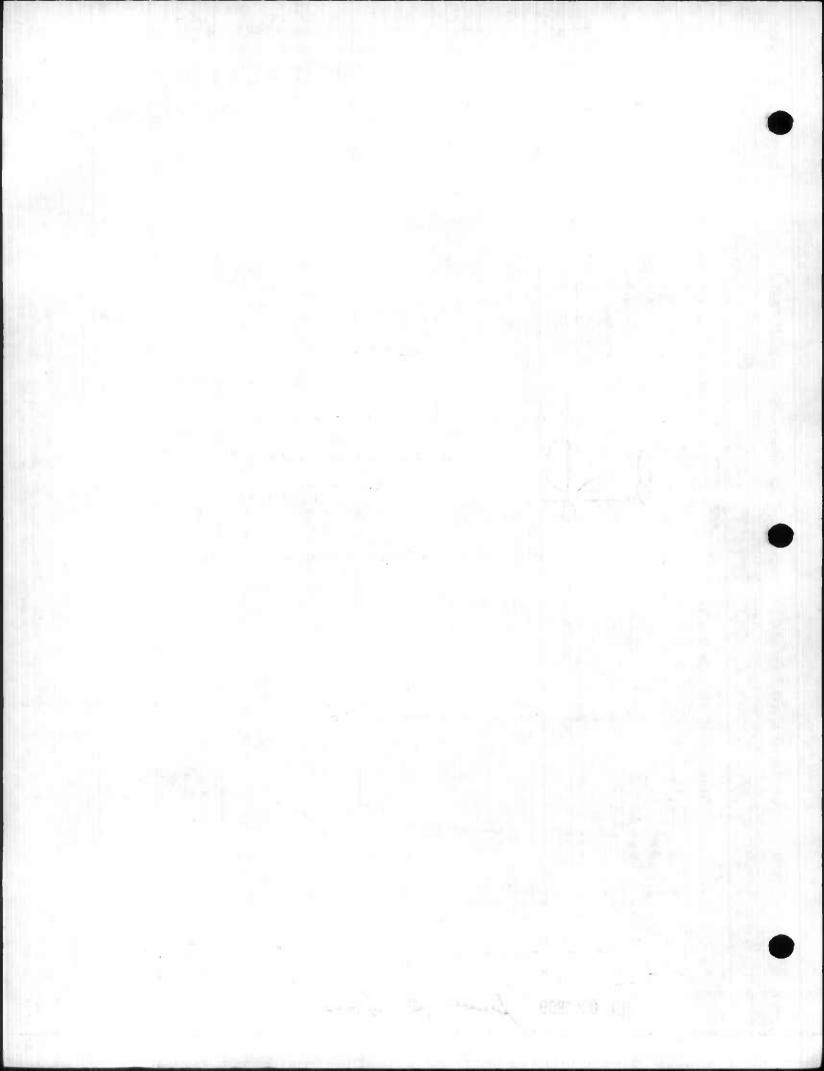
72 hours after death



### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 21043

1		Otato of Maryla			of Death		Reg. No.	21040
Physician	Decedent's Name (First, Middle, Last)					2. Dete of De Month	ath Dey	3. Time of Death
/Medical	Mary Agnes	Reyerson				June		999 8:30 PM
Examiner	4a Facility Name (If not institution, give	street end number)			4b. City, Town, or		4c. County	ol Death
4-	Mariner Health				Forest	Hill	Harf	ord
Funeral Director	5. Social Security Number 6. Security Number 214-14-8285 Usuel Residence of Decedent	7. Age (In yr.	s. last birthday) Yrs.	Months D	ear If Under 24 Hrs eys Hours Min.		Y. Year) 1919	9. Birthplace (State or Foreign Country) Maryland
Down Man	10a. Sfata 10b. County	10c. C	City, Town or Lo	ocation				10d. Inside City Limits
Mary Mary Lor	Maryland Harford	B.	el Air					1 ☐ Yas 2 ☑ No
128a notific	10e. Street and Number	D	C.A. 21.A.E.	10f. Zip Co	de		10g. Citizen of W	/hat Country?
3a o at D	2106 Deadora Road			2101	5		U.S.A.	
DESIGNOTE, MERYIANG 21215-UUZU  permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. Theoretin: if them 27 is marked other than "natural", or flows 23a or 28a-f show any injury or other traumatic avant, the Medical Earthon must be northed at once.  To Be Completed by Funeral Director	11. Meritel Stetus  1 Never Merried 2 Merried  3 Wildowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Giva Yeer or Detes:			of Hispanlc Origin? (S Cuben, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)	14. Race Bleck Specify:	- American Indian, k, White, etc. White
1 21215-00 ed within 72 hou ygiene. Per than "naturals. It is the good Completed"	15. Decedent's Edu	cation	16a. Dece	dent's Usuel O	ccupation	dilan	16b. Kind of Bu	siness/Industry
hin 7	(Specify only highest grade Elementery/Secondery (0-12)	College (1-4or 5+)	(Give	DO NOT use re	one during most of wo atired)	rking		
Z I with by the property of th	12th grade		Home	maker			Own Hom	e
Ce, Maryland 212  1 and 2 should be filed with! Heelth and Montal Hygiene. am 27 Is marked other than ther traumatic avant, first To Be Comp	17. Father's Nema (First, Middle, Last)				18. Mother's Ne	me (First, Middle,	Meiden Sumem	θ)
Vial Menta M	Harrison J. Rider				Grace	Marie Ca	arey	
sho sho	19e. Informant's Name/Reletionship (Ty	pe, Print)	19b. Maili	ing Address (Si	reet end Number or R	ural Route Numbe	er, City or Town,	State, Zip Code)
M selth 2 27 le	Jim Reyerson (Son)	)	2106	Deador	a Road, H	Bel Air,	MD. 21	015
Saltimore, semit. Peges 1 at Separtment of Hee mportant: If Hem into Injury or other and Injury or other a	20a. Method of Disposition		Pleca of Dispo	osition (Name o	nlece)	Date	20c. Location -	City or Town, Steta
Pages mant of h mr: if he ary or of	1 Nation 2 Cremation 3 NR	emoval Irom State			1 Gardens	7/3/99	Bel Air	, Maryland
ortan	21. Signature of Funeral Service License				ddress of Fecility	113133	DCI, MII	, Hary Ellic
D SOFT S	1 Dimi		S	chimune	k Funeral MacPhail Ro			
Physician /Medical Examiner	23a. Pert1. Entar the disease, or complishook, or heart teilure. List only or Immediate Cause (Final disease or condition resulting In death)	end	or as e conse	ne c	dying, such es cardia			Approximate Interval Between Onset end Deeth
je je		Due to	(or as e conse	qtence ot):				
D8/00, tificate be executed g physicien and as the burtal-trensit	Sequentielly list conditions, if any, leading to immediate cause. Entar Underlying Ceuse (Disease or Injury that initiated events	Due to	(or es e consec	quenca of):				
BOX 507 00, seth certificate be executed strending physicien and for use as the burial-frensit clan/Medical Examir	thet initieted events resulting In death) Lesf		(or as a consec	quenca of):				
death death	Part II. Other eignificant conditions con	tributing to deeth but not re	esulting in the u	inderlying caus	e given in Pert I	23b. Did 1	lobacco usa con	tributs to the cause of death?
s, r.C. BOX ss that the death cent gned by the attendin be detached for use. by Physician/M		renlen			4	20011232	Yes 2016	3 Probably 4 Unknown
ew require is been size the standing pleted							an autopsy rmed?	24b. Were autopsy findings available prior to completion of cause of death?
C 4 4 5 5	With the state of					101	res 2 No	Yes 2 No
certificate irector, pag	25. Was case referred to medical				26. Place of De	eth (Check only o	ne)	
	axaminer? 1 Yes 2 No	ospitel: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA	Other: Nursing I	Home 5 Resid	dence 6 □Othe	or (Specify)
oding Physics: After this funeral di	27. Menner of Death 1 Neturel 5 Pending 2 Accident invastigation	28a. Dete of Injury (Month, Dey Year)	28b. Time o Injury	M 28c.	Injury et Work? 1 Yes 2 No	1	now injury occurr	
To the Hospital or Attending P within 42 hours alser death completely filled in by the funer Completely filled in by the funer Medical Certification:	3 Suicide 6 Could not be determined	28e. Pleca of Injury - At building, etc. (Spec	home, ferm, str	reet, fectory, of	lice	28f. Location (S City or Tov		er or Rural Route Number,
othe Hospit ithin 24 hours othe Funera mplataly fill	29a. Certifier 1 Certifying Physical Check only 2 Medical Examir	ician: To the best of my kr er: On the basis of axemir and menner steted.	nowledge, deetl netion and/or in	h occurred et the vestigetion, in	ne time, dete end piece my opinion, deeth occi	e, and due to the urred et the time,	cause(s) and ma date and place, s	nnar as stated. and due to the cause(s)
To the To the comple	29b. Signeture and title of certilier			29c. Li	cense number		29d. Date signed	(Month, Day, Year)
	David 5.	Dum		0	32259		July 1.	1555
	30. Name and address of person who co				01 -	)	,	
	31. Date liled (Month, Day, Year)	عرين رو 32. Registrer's Sign	613	W, M	acthai			
State Registrar	JUI 0 2 1999	Dener	B.	Span	2			



State Registrar **DHMH 16 Rev 6/95** 

To the Within 2

edical

29a. Certifier

THEONORE 31. Date filed (Month, Dey, Year)

29b. Signature and Atte of certifier

32. Registrer's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 1999

111 Penn Street, Baltimore, Maryland 21201

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Washington, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and menner stated.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

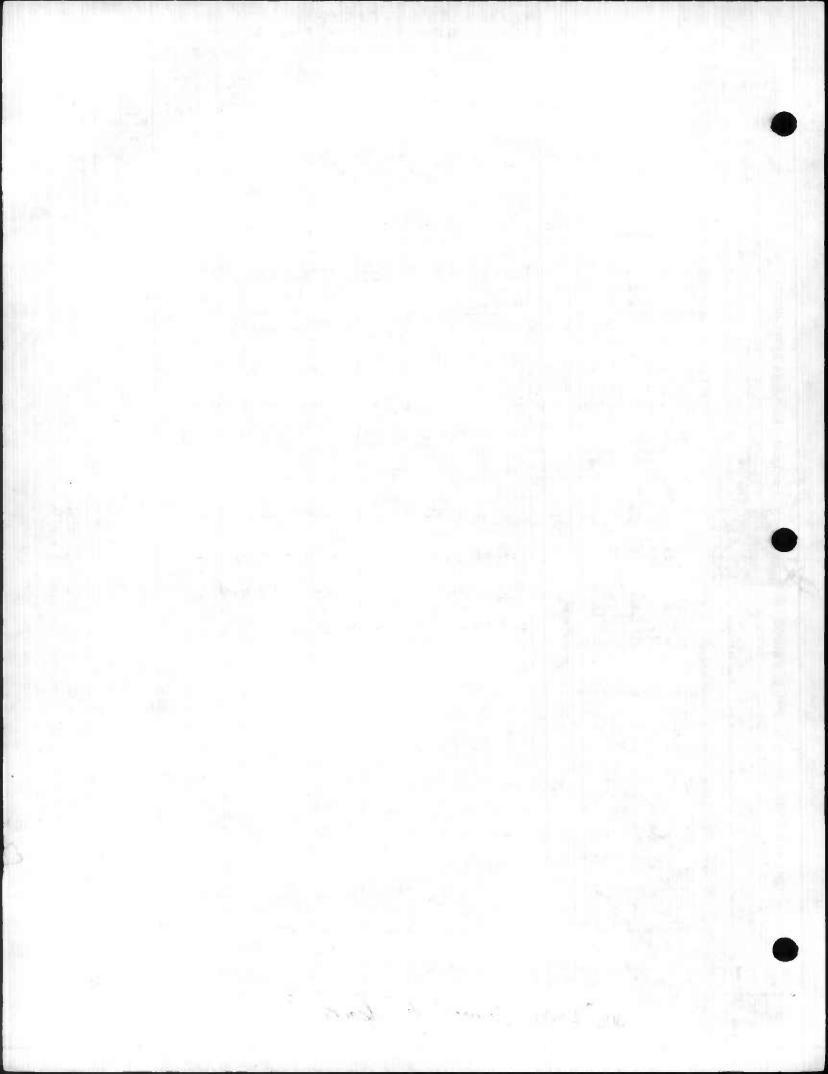
July 01, 1999

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 2 1 0 4 5

			Certifica	te of Death	Re	eg. No.	
hysician	Decedent's Name (First, Middle, I  And	rel, Rich	handson		2. Date of Deat Month	Day Y	3. Tima of Death 19 5 PM.
/Medical xaminer	4e Facility Name (If not institution, g University of MA		SYSTEM		Location of Death	4c. County of	
eral tor	Social Security Number     A     Usual Residence of Decadent	Sex 7. Age (In yrs.	Yrs. If Und Month	er 1 Year If Under 24 Hr S Days Hours Mir		Year) 99	9. Birthplace (State or Foreign Country) Umms, MD
'n	10s. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
I Director	10e. Street and Number	do Rd.	10f. 2	ip Code 12 44	10	Og. Citizen of Wh	at Country?
by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Evar in U	I,S. 13. Was Dec	edent of Hispanic Origin? (ecity Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race -	American Indien, White, etc. B/AC/C
Completed	15. Decedent's (Specify only highest g		16a. Decedent's Us (Give kind of v life. DO NOT	rork done during most of w	orking	16b. Kind of Busi	ness/Industry / A
To Be Co	17. Father's Name (First, Middle, Las	Walker		-	ame (First, Middle, M	Raiden Sumame)	7
-	19a. Informant's Name/Relationship	(Type, Print)		ss (Street and Number or F	Rural Route Number,	11	tate, Zip Code) , M.D. 21209
	20a. Method of Disposition 1 Burial 2 Cremation 3	□Removel from Stete	Plece of Disposition (Accemetery, crematory of	eme of	Date	20c. Location - C	ity or Town, Stete
9000	21. Separature of Funeral Service Lio	affirmed to the contract of th	· 22. Neme	and Address of Facility	Betts Fun	eral t	re, Maryland
	23a. Part L Enter the ductase, or co	mplications that caused the deel y one cause on each line.	th. Do not enter the m	N. CACOLINE ode of dying, such as cardi			Approximate Intervel Between Onset and Death
an cal ner	Immediate Cause (Final disease or condition resulting in death)	Massive	Cash	intestinal (	bleeding		I hour.
aminer		b. Disseminat	red Intra	versular Co	og watro	m	1/2 hon7.
Medical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Extreme	or es e consequence o Premontarión or as a consequence of	<b>y</b>			
Physician	Part II. Other significant conditions		sulting in the underlying	cause given in Pert I.	23b. Did to	bacco use conti	ribute to the cause of death?
by Phys					1 🗆 Ye	2 No 3	B Probably 4 Unknown
Completed by					24a. Was as perform		24b. Were autopsy findings available prior to completion of cause of death?
					1784	s 2 No	1□ Yes 2⊠ No
To Be	25. Was case referred to medical examiner?  1 1 4 7 es 2 No	Hospitel:	ER/Outpatient 3□ (	Other	eath (Check only on Home 5 Reside		(Specify)
Certification:	27. Manner of Death  1 SHatural 5 Pending 2 Accident investigati 3 Suicide 6 Could not determine	be con Standard and	28b. Time of Injury M	28c. Injury al Work? 1 Yes 2 No	28d. Describe ho	reet and Number	or Rural Route Number,
	29a. Certifier 12 Certifying P	building, etc. (Specil hysician: To the best of my kno		d at the time, date end plac	City or Town		ner as stated.
Medical	(Check only 2   Medical Expone)  29b. Signature and title of certifier	miner: On the basis of examina and manner steled.	ation and/or investigation	on, in my opinion, deeth occ	curred at the time, da	ate and place, an	Month Dev Year)
	P.I Com	~ FECTO 10,11	7	DO0539 LEREFN CIA	06	06-2	7-99
	PALANISAMY RATE	completed cause of death (Item	n 23a) (Type, Print) 10004, HIL	LGREFN CIA	APT-E	Coc.	LEXVILLE 20 30.
State	31. Date filed (Month, Day, Year)	32 Registrer's Signa		-11			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 7:00am Rice Clara 06 1999 /Medical 4a. Facility Name (If not institution, give street and numbar) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6406 Laurel Drive Locheran Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country)
 S. C. 7. Age (In yrs. last birthday) **Funeral** 1 M 2 CXF 96 Yrs Director 212-36-7831 Usual Residence of Decedent the Maryland show 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiena. Department of Health and Mental Hygiena. Inmocrant: If term 27 is a marked other than "natural; or items 23a or 28a-f show any Injury or other traumatic event, in wedital Examples. 1XXYes 2 No Director NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 6406 Laurel Drive 21207 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 1 ☐ Yes 2 ☐ No if Yas, Giva Year or Dates: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 Specify: Black 1 ☐ Yes 2 No Specify: by 3 ☑ Widowed 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) 8th Grade Domestic Worker Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Johnny Fernandez Virgia Smith 19a. informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise V. Allen-Daughter 829 N. Chapelgate Lane, Balto Md 21229 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD National Mem. Park 7/3/99 Laurel, MD 21. Signature of Funeral Solvica Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Avenue Baltimore, Md 21215 23a. Part1. Fitter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or hour failure. List only one cause of each line. Physician immediete Ceuse (Final disease or condition resulting in death) /Medical (000N 2 (200 Examiner Due to (or as e consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or as a consequence of): signed by the a Part il. Other algolificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes No Records, Completed by 24b. Were autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? After this cartificate has I funeral director, page 2 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director; After this carific. Be 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitei: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? 5 Pending investigation 1 Watural To the Hospital or Attendin within 24 hours aftar daath. To the Funeral Director: Af completely filled in by the fu 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28a. Place of injury - At home, farm, streat, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 T Homicide 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as steted.

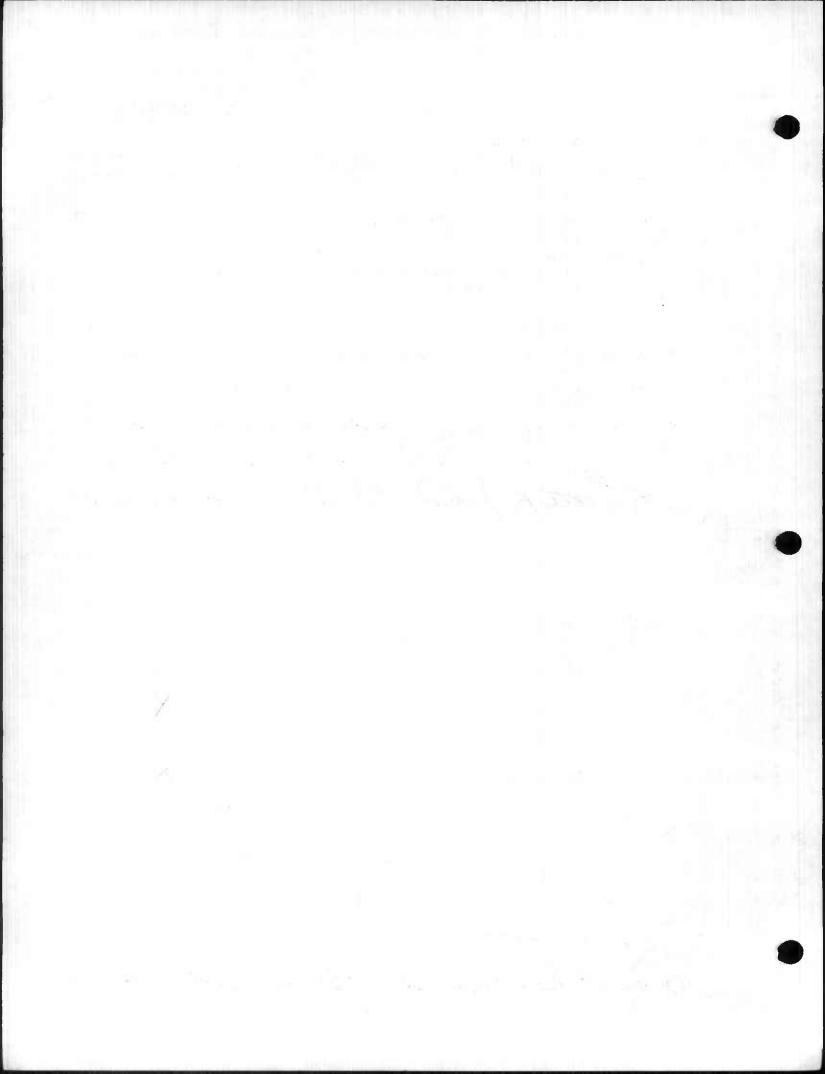
2 Medical Examiner: On the best of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only 250. Signature and title of certifier Name and accress of person wng completed cause of deeth (Item 23e) (Type, Print) OLD COHRT ROAD

State
Registrar

DHMH 16 Rev 6/95

31. Date fited (Month, Day, Year)

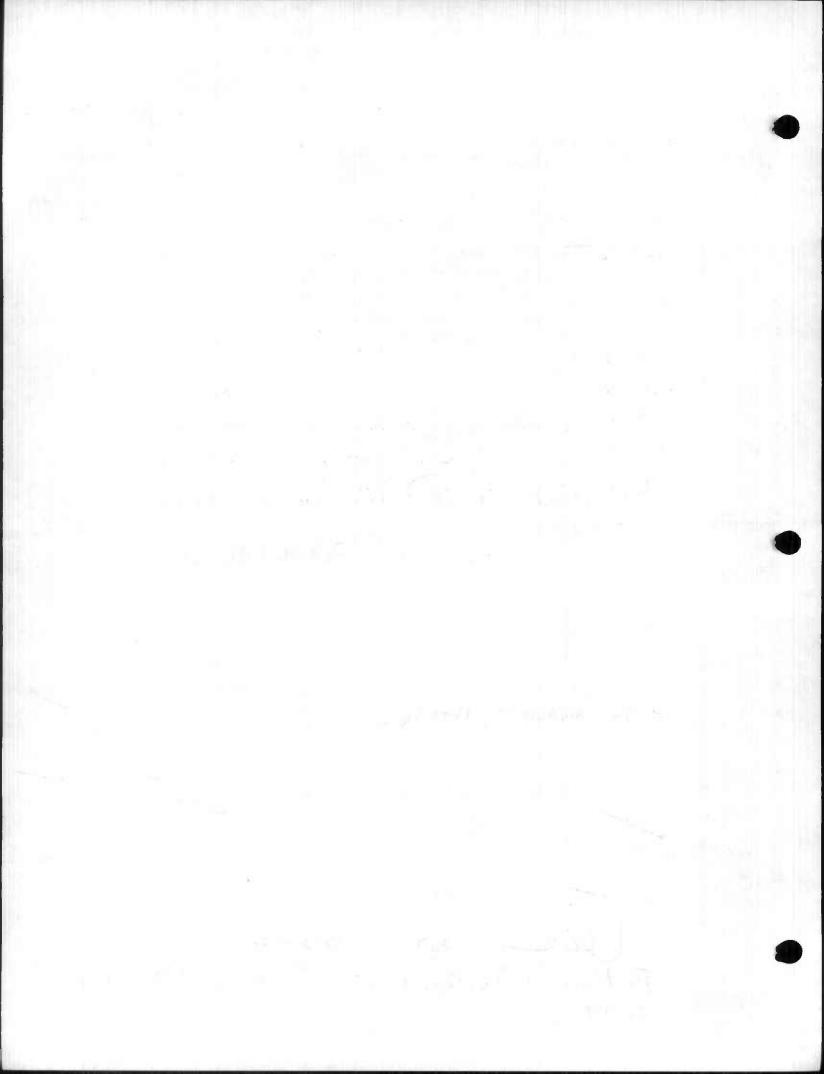
32. Registrer's Signature



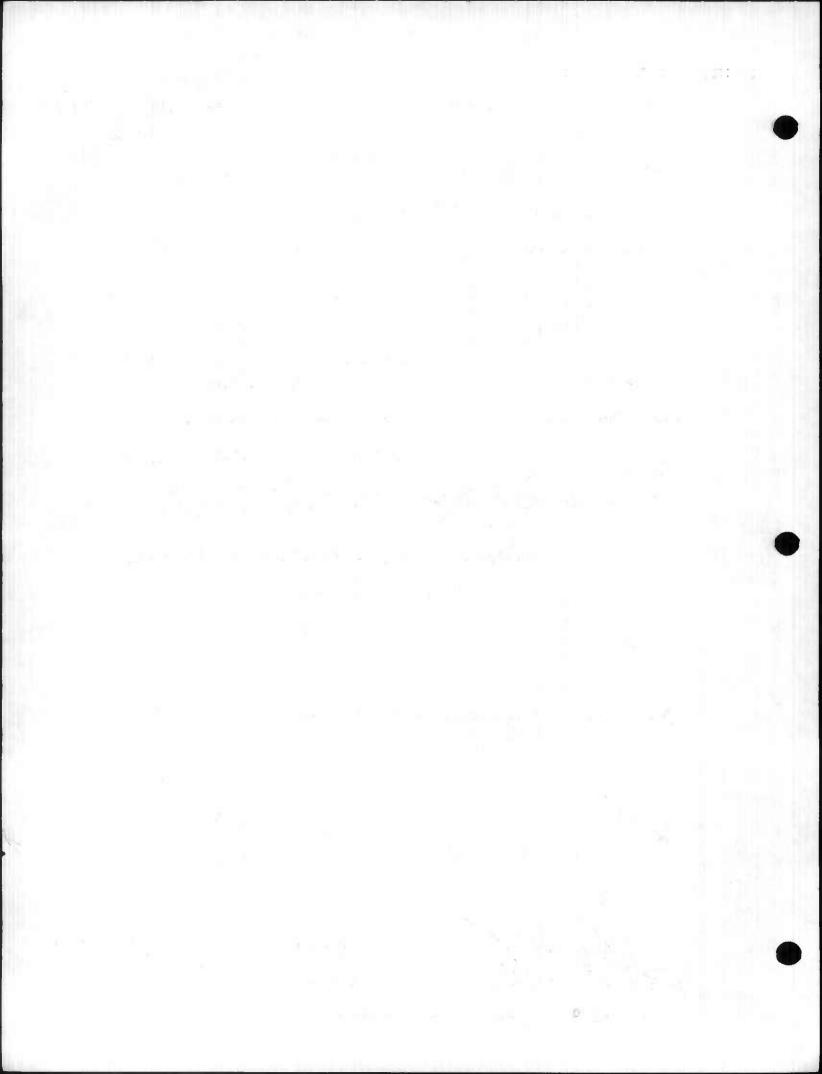
### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 21017

					,	Certificate of	Death		Reg. No.	2 6	1041
			1. Decedent's Name (First, Middle, La	st)				2. Dete of D	eath		3. Time of Death
	Physic			Derek	J. Ric	hardson		Month 6	29 10	Yeer 999	8:44 a.m.
ž	/Medi Examii		4e. Fecility Neme (If not institution, give	e street and number)			4b. City, Town, or				0.77 0.111.
1	LAGIIII	ICI	1714 Park Ave	nue			Baltimo	re	N/A		
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last bird	hday) If Under 1 Year	If Under 24 Hrs	8. Dete of B	irth	9. Birthplac	ce (State or Foreign
	Director		220-98-8291	<b>Ø</b> M 2□ F	35	Yrs. Months Days	Hours Min.	(Month, P	0-1963	Country	"Md
-	D		Usual Residenca of Decedent								
	how		10a. State 10b. County		10c. City, Towr	or Location				10d.	. Inside City Limits
	Ma F	cto	Md N/	A	Balt	imore					1 Yes 2 No
	4 th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	Vhet Country	17
	23. E3.	<u>a</u>	1714 Park Aven	ue		21217	7		USA		
	dea dea	Funeral	11. Marital Status	12. Wes Decedent Ex Armed Forces?	ver In U,S.	13. Was Decedent of H If Yes, specify Cub	Hispenic Origin? (S en, Mexican, Puerl	pecify Yes or N to Rican, etc.)	lo- 14. Race	e - American ck, White, etc	
20	72 hours after death with the Manyland natural", or items 23s or 28s-f show ores Examiner must be nutified at	F	1 ☐ Never Married 2 ☐ Married	1 Yes 2 No		1 □ Yes 2 ◯ No			Specify	0.7	
Š	ural,	d by	3 🗖 Widowed 4 □ Divorced	Yeer or Detes:							
'n	should be filled within 72 hours aftar death with the Manylan nd Mental Hygiene. markad other than "natural", or items 23a or 28a-f show imatic event, if a Medical Examiner mant be nuffled at	Completed	15. Decedent's Ed (Specify only highest gre	lucatio <i>n</i> de completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of wo	rking	16b. Kind of Bu	isiness/Indus	stry
7	withir ene. then	E	Elementary/Secondary (0-12)	College (1-4or 5+	)	Disabled	a)		N/A		
7	Hygie Ther or,	ပိ	12th grade  17. Fether's Name (First, Middle, Last)	N/A		DISADIEU	18 Mother's Nar	me /Firet Middle	e, Maiden Surnem	(a)	
Maryland 21215-0020	Mental I Merkad of arkad of	Be	William Watts						•	0)	
2	should be filed within nd Mental Hygiene. marked other than "umatic event, the Ma	70	19a. Informant's Name/Relationship	Time Print)	106	Mailing Address (Street	Brenda R			State 7in Co	adal
<u>8</u>	d 2 s th an 7 Is r										300/
ຜົ	1 an Heal em 2		Brenda Oglesby ~	Mother	20b. Place of	007 Bareva [ Disposition (Name of y, creme <i>tory or other pl</i> a	Koad Bal	timore,	20c. Location -	L215 City or Town	1. Stete
Baltimore,	nt of nt of : If it		1 Burlal 2 □ Cremation 3 □					7-1-99			
=======================================	rtani		4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Lican		WOOdir	awn Cemetery		/-1-99	Baltimo	re, Mc	3
Ba	permit. Pagas 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other treumatic es once.		21. Signal of the control of the con	1	10	March F	/H West				
_			Chabriel		SVE		abash Ave				
			23a. Part1. Enter the disease, or com- shock, or heert feilure. List only	one cause on each line	ne death. Do r ).	not enter the mode of dyl	ng, such as cardia	c or respiratory	errest,	in	pproximate nterval Between Inset and Death
,	Physician /Medical		Immediete Ceuse (Final	1.4-	1	- n		O 4	- 0		11001 0110 00011
	Examiner		disease or condition resulting In death)	e.	CASI	ATIC RI	JNAL (	ANC	ER_		
		ē		С	oue to (or as a	consequenca of):					
	Insit	Examiner		b		2 0				1	
~	al-tra	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D	rue to (or as e o	consequenca of):					
68760,	ificate be executed g physician and as the burial-transit	cai	Cause (Disease or injury that initiated events	c		anacquence of);					
9	rificat ng phy as th	Medical	resulting In death) Last	D	ue to (or as e c	onsequenca of):					
Box	attending for use	2		d							
m	death e atte	cia	Part II. Other algnificant conditions of	ontributing to death but	not resulting Ir	the underlying cause of	ven in Part I	23b. Did	i tohacco uee co	otributa to th	he causa of death2
o.	The law requires that the death certificate be executed ate has been signed by the attending physician and paga 2 should be detached for use as the bural-transit	Physician/		the state of the state of the		CONTRACTOR OF THE CONTRACTOR OF			Yes 2□No	3 Probat	
ις)	s tha	by P	AIDS, ANA	REMITA,	VVASIL	NG					
Hecords,	w requires that been signed to should be date								s en eutopsy formed?		e eutopsy findings eble prior to
ပ္က	s bee	plet						por	iomea:		pletion of cause
Ľ	he law e has	Completed						1	Yes 2 No	101	Yes 20 No
<u> </u>	ifficat for, p	Bec	25. Was case referred to medical				26. Place of De				
5	Physiclan: r this certific aral director,	0	exeminer? 1 Yes 2 No	Hospitel: 1 ☐ Inpatien	t 2 ER/Ou	tpatient 3 DOA Ott	her: 4 Nursing I	The state of the s	sidenca 6 □Oth	er (Specify)	
0	y Phy eral	n: T	27. Manner of Death	28a. Date of Injury (Month, Dey		ime of 28c. Inju			how injury occur	1.1 //	
0	ath. :: Afte	atio	1 ☐ Matural 5 ☐ Pending 2 ☐ Accident Investigation		7 667)		rk? ]Yes 2□No				
Division of Vital	Attending at death. ector: After by the fune	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	200. Placa of injul	y - At home, fa	rm, street, factory, office			(Street and Numb	er or Rural R	Route Number,
5	s afte	Cert	4   Hornicide	building, etc.	(Specify)			City of T	own, siele/		
	To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, paga		29e. Certifier 1 Certifying Ph	ysician: To the best of	my knowledge	, death occurred at the ti	me, date and place	a, and due to the	e cause(s) and me	nner es state	ed.
	in 24 he Ft	edical	(Check only 2 Medical Exam	and menner state	examination and ed.	d/or investigetion, in my	opinion, death occu	urred et the time	e, date and place,	and due to th	ie cause(s)
	To To the Com	Σ	29b. Signature and title of contilled			29c. Licens			29d. Date signe	d (Month, Da	ly, Year)
1			1 4		MI	D	52396	+	6/30/	77	
			30. Name and address of person who	completed cause of de	ath (Item 23a)	Type, Print)	2 4		IAN	-	
			La Muasi	1001 (0	thocke	1 Sheet	52396 , Ball	MORE	MIS	2420	) [
	Sta	ite	31. Dale filed (Month, Day, Year)	32. Registrar	's Signature	4	1		1	•	
	Registi	rar	JUL 0 2 1999	Denew	B. 1	parket					
DUI	4H 16 Rev 6/9	5	-		//						



AMEND ITE	۷:	#5 PER F.H. G773 7-10	5-99 WR.	naryland /	Certificate of			Reg. No.	
Physici /Medi		Decedent's Name (First, Middle, John		p Sr.			2. Deta of De Month June	29,1999 Yeer	3. Time of Deeth 10:17 am
Examir		4a. Facility Name (If not institution, 5932 Clayton	giva straet and numbe. AVE .	r)		4b. City, Town, or L Raspb		4c. County of Daa Baltin	th nore
Funeral Director		/05-10 <del>-5389</del> 5384	5. Sex 7. A	age (In yrs. last b	oirthday) If Under 1 Yaar Months Days		8. Data of Birt (Month, De 8-20-	y, Year) 9. Bir	thpleca (Stete or Foreign buntry) MD
Maryland a-f show	tor	10e. Stete MD Balt	imore	10c. City, To	wn or Location Raspburg				10d. Inside City Limits 1 ☐ Yes XX No
th with the 23s or 28	Funeral Director	10e. Street and Number 5932 Clayto	n Ave.		10f. Zip Code	21206		10g. Citizen of Whet Co USA	ountry?
Aaryland 21215-0020 2 should be filed within 72 hours efter death with the Maryland end Mental Hygiene. Is marked other then "natural", or items 23e or 28e-1 show reumatic event, the Medical Examinet ment be notified at	þ	11. Marital Status  1 Never Merried 2 Marrie 3 Widowed 4 Divorced	12. Was Deceden Armed Forces d 1  Yes 2  If Yes, Give Year or Dates	<b>X</b> ⁄10	13. Wes Decedent of If Yes, specify Cut		pecify Yes or No Ricen, etc.)		
Maryland 21215-0020 d2 should be filed within 72 hours ef th end Mental Hyglene. 71s merked other then "natural", or traumatic evant, In Medical Exam	Completed	15. Decedent's (Specify only highest Elementary/Secondery (0-12)	Education grade completed)  College (1-4or	5+)	e. Decedent's Usuel Occu (Give kind of work done life. DO NOT use retin	petion during most of work ad)	king	16b. Kind of Business	
Maryland 2 d2 should be filed th end Mental Hygin 7 Is marked other traumatic event,	To Be C	17. Fether's Neme (First, Middle, Lannie Repp	ast)	,	Oridación		e (First, Middle, . Riser	Maiden Sumeme)	
Mary alth end N 27 Is mar		19e. Informent's Name/Relationshi Joseph Repp / s	p (Type, Print) ON	15	9b. Mailing Address <i>(Stree</i> 5932 Clayt				
Baltimore, Maponeri. Pagas 1 and 2 s Department of Health en Important: If Item 27 1s is any Injury or other trau		20e. Method of Disposition  1   ☐ Buriel 2 ☐ Cremetion 3  4 ☐ Donetion 5 ☐ Other (Spe		cemei	of Disposition (Name of ery, cremetory or other pla udon Park	oce)	Date 7-1-99	20c. Location - City or Baltimore,	
Balti permit. Departri Importa any inju		21. Someture of Funeral Service Li	center	00>		ess of Fecility Osedale F hesaco Av			1237
Physician /Medical Examiner		23e. Part1. Enter the disease, or c shock, or heart feilure. List of Immediate Ceuse (Final disease or condition resulting in death)	nly one ceuse on eech	ine.	onot enter the mode of dy  the code  consequence of):	lng, such es cerdiac	or respiretory er	rest,	Approximate Intervel Between Onset end Deeth
Records, P.O. Box 68760, The law requires that the death cartificate be executed the has bean signed by the attending physician and toage 2 should be deteched for use as the buriel-transit	n/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in daeth) Lest	b	Hyp Due to (gras	e consequence of):				
IS, P.O. Be res that the death igned by the atter be deteched for it	Physicia	Pert II. Other significant condition  Non- w Sul	s contributing to death		In the underlying cause g	iven in Part I.	23b. Did 1	1	e to the causa of death?
Vital Records, lolen: The law requires the cardificate has been signe rector, page 2 should be c	Completed by Physician/M		0			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	24e. Wes	en eutopsy 24b.	Were eutopsy findings eveilabla prior to completion of ceuse of deeth?
		25. Wes cese referred to medical				00 00	1 🗆 1	1	1 Yes 2 No
₩ % w 0	To Be	exeminer?	Hospital: 1 ☐ Inpat		Dutpetient 3LI DOA		ome 5 Resid	dence 8 Other (Spe	ocity)
Division of To the Hospital or Attanding Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	27. Manner of Deeth  1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no	201	ay Yeer)	Time of Injury M 1 I	ny et ork? ] Yes 2 □ No		now injury occurred	
Divi	Certif	4 Homicide determin	ed 286. Piece of it	njury - At home, etc. <i>(Specify)</i>	ferm, street, factory, office		28f. Location (S City or Tox	Street end Number or F vn, Stete)	urel Route Number,
Ne Hospi n 24 hou ne Funer plately fill	edical	29a. Certifier (Check only one)	Phyelclen: To the best caminer: On the bests and menner s	of exemination e	ge, deeth occurred et the t and/or investigation, in my	ime, date end plece, opinion, deeth occur	end due to the red et the time,	ceuse(s) end menner e date end plece, end du	s steted. e to the ceuse(s)
To the To the Committee Co	W	29b. Signeture end title of printing	lph		29c. Licen	se number		29d Dete signed (Mon	th, Dey, Year)
		30. Name and eddress of person with	o completed cause of	death (Item 23a	1	דבוג לו	7	/	1 1
Sta Registr		31. Dete filed (Month, Dey, Year)	32. Regis	trar's Signeture	Sparks		•		



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99

99 2104

Physician				Cel	rtificate	7 OI I	Deam		Re	eg. No.		
	Decedent's Neme (First, Middle, EDITH	Last)			5	SAME	T		2. Date of Deat Month JUNE 29	h Day	Year	3. Tima of Dea 5:00 Al
/Medical Examiner	4a Facility Name (# not institution,  1 SLADE AVENU		er)			4		wn, or Lo	ocation of Death	4c. County		IMORE
Funeral Director	223-05-8331	3. Sex 1 □ M 2 PF 7.	Age (In yrs. la	ast birthday) 30 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, SEPT. I	, 1918	9. Birthpla Country	ce (State or For y) VA
-f show fied at for	Usuel Residence of Decedent  10a. Steta 10b. County  MD BAT.T	IMORE		TIMOR							100	d. Inside City Lin
Nems 23a or 28a-f shores must be notified at uneral Director	10e. Street and Number  1 SLADE AVENU			22.1010	10f. Zip	Code	2120	)8	10	0g. Citizen of V		y?
Example Dy F	11. Marital Status  1 Never Married 2 Marrie  3500 Midowad 4 Divorced	12. Was Decede Armed Force d 1 Yas 2 H Yes, Give Yaar or Data	es? ZNo		Was Deceded Yes, special Yes 2		ispanic Ori an, Mexicar Specify:		ecify Yes or No- Rican, etc.)		e - American ck, Whita, at WHI!	c.
ygiene. wr than 'netur t, the Medical Completed	15. Decedent's (Specify only highest Elementery/Secondary (0-12) 12		or 5+)	(Give	dent's Usua kind of wor DO NOT us WIFE	k done d	during mos	t of work	ing	OWN HO		stry
hartai Hy had othe lic event, o Be C	17. Fathar's Neme (First, Middle, La HYMAN	ist)		COHEN			18. Mothe		e (First, Middle, N	Aaiden Suman	CAPL	AN
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Departm Importa any inju ansa	21. Signature of Funeral Service Li				2. Name and			ty S	SOL LEVIN	NSON &	BROS.	, INC.
ding physician and se as the burlaktransit una	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. \( \lambda_1 \)	Due to (or Due to (or	es a consec Met as e consec as a consec	quence of):	as	res					6 more
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certificate he rector, page	25. Wes case referred to medical						OC Phon	a of Door	1□ Ye	/-	10	Yes 2□ No
10 O 10	25. Wes case referred to medical examiner?  1 Yes No	Hospitel: 1 Inp	atient 2 E	R/Outpatier	nt 3□ DO	A Oth	or	ursing Ho	th (Check only on ome 5 A Fleside	ince 6 Oth	er (Specify)	
After the funeration:	1 Netural 5 Pending 2 Accident investige			28b. Time of Injury	М		yat k? Yes 2□		28d. Describe ho	ow injury occur	red	
within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificat	3 Suicide 6 Could no determin	28e. Plece of building,	Injury - At hor etc. (Specify)	ne, ferm, str	reet, fectory,	office			28f. Location (St. City or Town		per or Rurat	Route Number,
in 24 hour he Funer pletely fill edical	29e. Certifier (Check only one)  Certifying  Certifying  Certifying  Certifying	Physician: To the be aminer: On the basis and menner	s of examinetic	riedge, death on end/or im	n occurred a vestigation,	t the tin in my o	ne, date an pinion, dea	id place, ith occur	and due to the ca red at the time, da	ause(s) and me ate end place,	anner as sta and due to t	ted. the cause(s)
To the comple	29b. Signatura and title of certifiar	. ~	2		29c.	License	e number		25	9d. Date signe		ay, Year)

**ORIGINAL** 

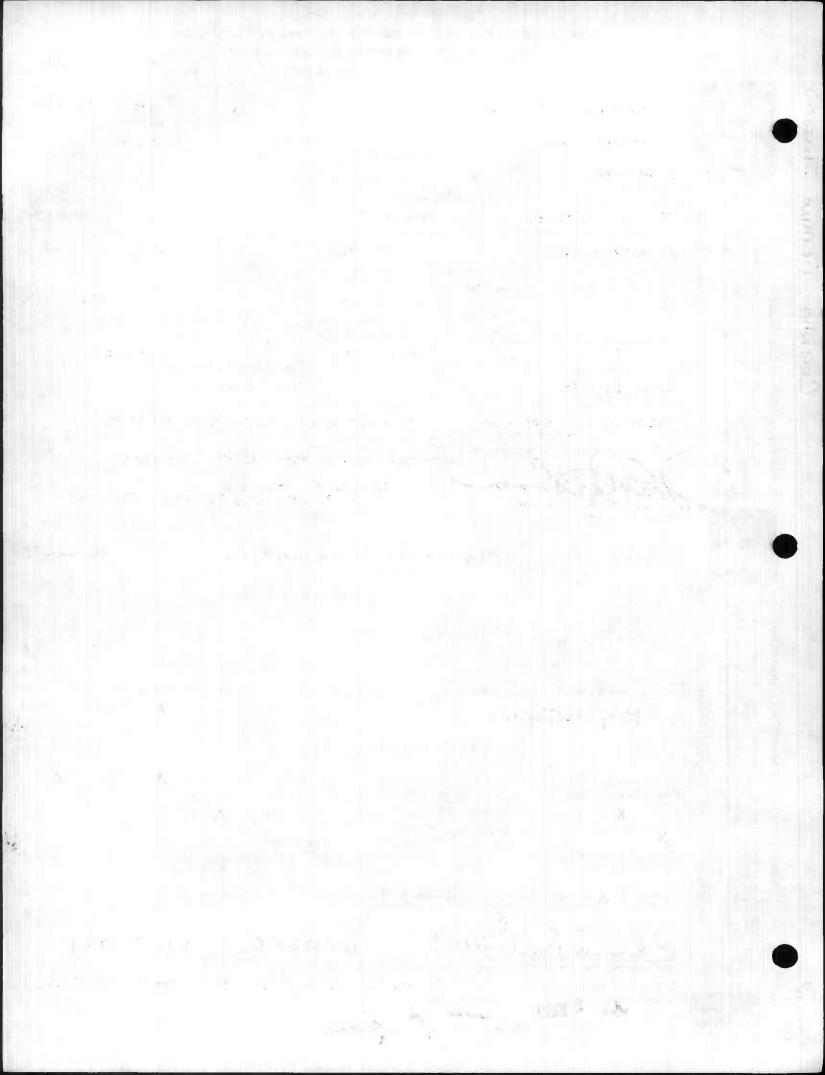
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**DHMH 16 Rav 6/95** 

Registrar



### Please Type or Print In Biack Indellbie ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 1999 1, 2:15am Calvin Stoltzfus Ju<sub>1</sub>y Herbert 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care Ruxton Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Deys Months 1₩ M 2□ F 70 Feb 15, 1929 Pennsylvania 201-24-4357 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21204 1307 West Joppa Road 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien. Black, White, etc. I ☐ Yes 2 ☑ No 1 Never Merried 2 Married 1 Tes 2 No Specify: 3 Widowed 4 Divorced Yeer or Detes White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Communications 12 04 Engineer 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) John Κ. Stoltzfus Mamie Holtzappel 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) 1307 West Joppa Road, Towson, Maryland 21204 Constance B. Stoltzfus/Wife

20b. Place of Disposition (Name of cemetery, cremetery or other place) Crematory

22. Name end Address of Fecility Lemmon Funeral Home 10 W. Padonia Road,

Baltimore-Washington

a, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

7/2/99

20c. Location - City or Town, Stete

29d. Date signed (Month, Day, Year)

July 1, 1999

Timonium, Maryland

Laurel, Maryland

**Physician** /Medical

Department of Important: If any Injury or page.

**Physician** 

/Medical

Examiner

10a. Stete

20e. Method of Disposition

21 Synature of unerel Service License

1 ☐ Buriel 2 Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

Directo

Funeral

þ

Be Completed

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiena.

ant: If Item 27 is marked other than "natural", or items 23a or 28a-f ahow ury or other traumetic event, the Medical Exeminar must be notified at

Baltimore, Maryland 21215-0020

Examiner

Examiner sician and buriel-transit Completed by Physician/Medical Be Aftar 24 hours after death. filled in by

or Attending Physician: The law requires that the death certificate be executed

this

Hospital

Box 68760.

Division of Vital Records, P.O.

Immediate Cause (Finel disease or condithur resulting in deeth)	Acute	Renalt	Failure		Onset and Death
resulting in death)	b. Acute	r es e consequence ef):	al Hemo	whage	2-worths
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	c. Hyper	r es a consequence of):		0	1
thet initiated events resulting in deeth) Lest	Due to (o	r es a consequence of):			
Part II. Other significant conditions of Atrial Fibra	contributing to death but not res	ulting in the underlying c	ause given in Pert I.	23b. Did tobacco use co 1 ☐ Yes 2 12 No	priribute to the cause of death
Sub divial	bewate	omas		24a. Wes an eutopsy performed?	24b. Were autopsy findings available prior to completion of cause
Insulin a	dependent	diabete	a mellit	1□ Yes 2√No	of death? 1 □ Yes 2√2 No
25. Wes case referred to medical examiner?	Hospitel:			eth (Check only one)	
1 ☐ Yes 2 💢 No	1 Inpatient 2	ER/Outpatient 3□ DC	A Other: 4 Nursing I	Home 5 ☐ Residence 6 ☐ Ott	ner (Specify)
27. Menner of Death  1 ② Neturel 5 Pending investigation	28e. Dele of Injury (Month, Dey Year)	28b. Time of Injury M	8c. Injury et Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occur	med

Medical Certification: To 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 6 Could not be determined 281. Location (Street end Number or Rural Route Number, City or Town, Stefe) 3 ☐ Suicide 4 Homicide 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end placa, end due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one)

29c. License number

D25569

State Registrar

JUL

ancis

30. Name end address of parson who completed ceut deeth (Item 23sf (Type, Print)

29b. Signeture end titre of certifier

31. Date filed (Month, Dey, Year)

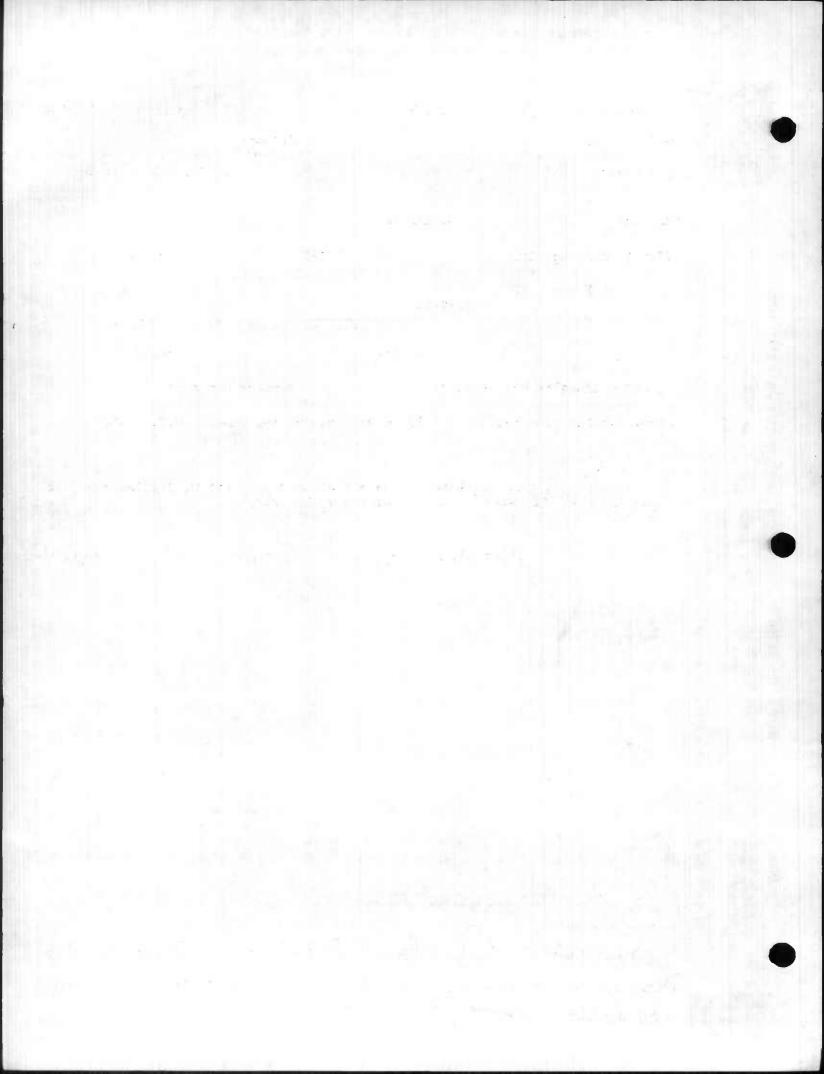
1205 York Road, suite 24, Lutherville, MD Francis Wiegmann, M.D. 32. Registrer's Signeture

Since Since Since

### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 21052

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ledical aminer	4	a Fecility Nem		tion, give	e street end	number)		7	-011	4b.	City, Town, or	Location of Dea	th 4c. C	County	of Death	
		5365 A	Carr	iage	Ct.						Baltimo					
eral ctor	(	. Social Securit	2494	6. Se	ex □ M 2 🛣	7. Age	(In yrs. les	st birthday) Yrs.	If Under Months		If Under 24 Hrs Hours Min		rth ey, Year) 6, 19	57	Coun	lace (State or For try) ginia
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Be (		7. Father's Nar	ne (First, Midd	lle, Last)						1	8. Mother's Na	me (First, Middl	e, <i>Maid</i> en S	Sumem	(0)	
10		Howard	Willo	eghb	y Whi	taker	, Jr.				Barba	ra Donc	ourt			
Ċ		19a. Informent's	Name/Relation	onship (7	Type, Print)			19b. Mailing	g Address	s (Street en	d Number or A	ural Route Num	ber, City or	Town,	State, Zip	Code)
	]	Barbara	Whita	ker/	mothe	r		131 C	Her	itage	Hills,	Somers	, N.Y		10589	)
	20		Disposition 2 Cremation 5 Other			rom State	20b. Pia	ca of Dispos netery, crem	sition (Ne netory or o	me of other piece)		Date	20c. Loc	ation -	City or To	wn, State
	2	21. Signature of				Dir	ector			nd Address Anatoi	my Boar	d, 655	W. Ba	lti	more	Street
	2	23e. Part1. Ent shock, or	Meg	or come	Olications to	nat caused	the death.	Ва	1tim		MD 212 such as cardia	01 c or respiratory	arrest,	-	1	Approximate Interval Between
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# CALVIN B. SCRU66 Baltimore, Maryland 21215-0020

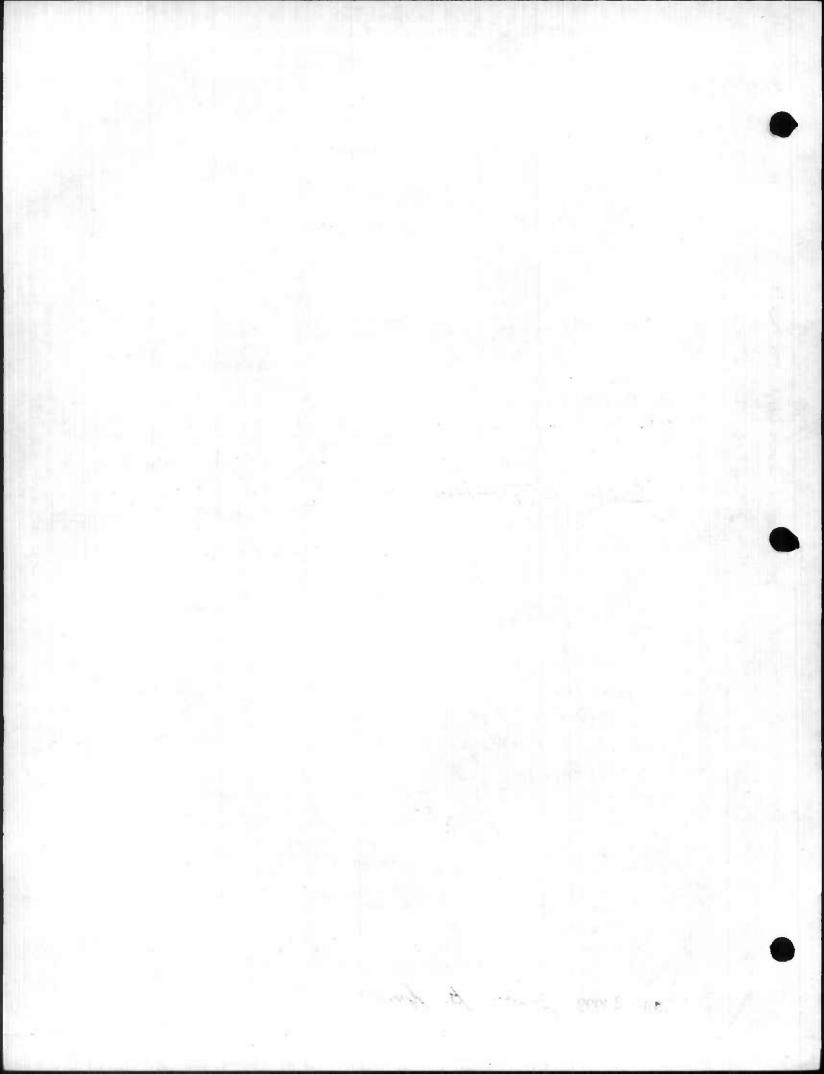
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death 3. Time of Death JULY **Physician** 0.320 CALVIN SCRUGGS, SR. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) **Examiner** CHURCH HOME HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months 216-42-3676 53 1,1945 MARYLAND Director DEC. Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Instda City Limits nem  $z_7$  is marked other than "natural", or items 23s or 28s-f show other treumstic event, the Medical Examiner must be inclined as 1 Yas 2 No Director MARYLAND BALTIMORE PIKESVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8013 SUNSTONE CIRCLE 21208 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Nevar Married 2√ Married 1 Yas 2 No 1 Yas 2 No Specify: Specify: AFRO-AMERICAN p 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) one(continous) MORTICIAN FUNERAL 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Pages 1 end 2 should be nent of Health and Mental WELFORD J. SCRUGGS SALLIE J. BUTTS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relettonship (Type, Print) 8013 SUNSTONE CIRCLE BALTO, MD. 21208 BERNADINE V. SCRUGGS wife 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Buriat 2 ☐ Cramation 3 ☐ Ramovat from Stata RIDGE CEMETERY ULY 8, 1999 PIKESVILLE, MD. 4 □ Donetion 5 12 Other (Specify) CR 461 DRUID 21. Signature of Funaral Sarvice Licenses 22. Nama and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. ying, such as cardiac or respiretory errest, 21213 Approximate Intarval Between Onsat and Daath 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. **Physician** Immediata Causa (Finel disaasa or condition rasulting in daath) /Medical CHRONIE LYMPHOCYTIC LEUKEMIA, STAGE I 4 ears Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Disaase or trijury that initiated eventa rasulting th death) Last Dua to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by ti should be detach 3 Probably 4 Unknown 1 Yes 2 No NON-HOBGKINS LYMPHOMA 24b. Were autopsy findings available prior to completion of causa of daath? Completed DEHY DRATION 24a. Wes an eutopsy MALNUTRITION 1 Yas 2 No 1 TYas 2100 Division of Vital To the Hospital or Attending Physicien: within 24 hours after deeth.

To the Funeral Director: After this cartificat completely filled in by the funeral director; p 25. Was casa rafarred to medical examinar? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 2 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending invastigation 1 ☐ Yes 2 ☐ No 3 Suicida 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Ptace of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 I Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and mannar stated. edical 29e. Certifier (Check only one) 29b. Signatura and titia of certifiar 29d. Data signed (Month, Day, Year) 29c. License number med. Specialist Marandres 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltibor, Mayland MD. us adway NENELISA NA VARRO 100 N. Se se Hegistrer Signature Registrar

O1 HH



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 9320 1999 :45Ar 7 JUNI 2 /Medical b. City, Town, or Location of Death 4a. Facility Name (If not institution, giva street and number) 4c. County of Deeth **Examiner** If Under 24 Hrs. 8. C 4316 KOAD GRAC HARFORD 2100 5 If Under 1 Year Birthplece (Stata or Foraign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year **Funeral** Months Deys Hours Min. 1 MM 2 □ F 52 Yrs. JAYSA 1947 MARYLAND Director 312288309 Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location is 1 and 2 should be filed within 72 hours after death with the Marylen of Health and Mental hyghen. Heart at 1 stracked other than "naturel", or items 23a or 28a-f show other traumstic event, "as Madical Examines must be notified as 10d. Inside City Limits 1 ☐ Yes 2 No Director MARYLAND YLESVILLE HARFORL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? D. S. A KOAD 4316 COIRDA. 21139 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Bleck, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 12 should be filled within 72 hours after on and Mental Hyglene. 1 Never Merried 28 Married 2 No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: TIKW à Specify: 3 Widowed 4 Divorced Year or Detes: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry FEOSRAL GOVS College (1-4or 5+) Elementary/Secondary (0-12) YRS-12762 OSTRUCIOR ABSROSS 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maldan Sumama) Be 1052PH KOSINBIRGIR ZINJA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 21/32 GRACETON KOAD 4316 1 JARYLAND LINDAI 20a. Method of Disposition 20b. Place of Disposition (Nama of cametery, cramatory or other place) Date 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important: If It any Injury or o 2 107A 1 Burlal 2 ☐ Cremation 3 ☐ Removal from State BILFTIR LABOTEL BURIR. PARYLAND 4 Ponation 5 □ Other (Specify) 22. Name end Address of Facility 21. Signature of Funeral Service Licensee -BURIR, P.A. 3 NEWPORT DRIVE FOR and the caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest 23a. Part1. Enter the disease, or complication shock, or heart tailure. List only one to Physician Immediate Cause (Final disease or condition resulting In death) /Medical . BRain Word Examiner Due to (or es a consequence of): Examiner sician and burief-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting In death) Last Due to (or as e consequence of): ettending physician for use as the burie Box 68760 certificate be Physician/Medical Due to (or as a consequence of) P.O. e eu Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Deen has certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury et Work? 28d. Describe how Injury occurred After ! Certification: or Attending Feffer death. 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) filled in by 4 Homlcide 24 hours e Hospital edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

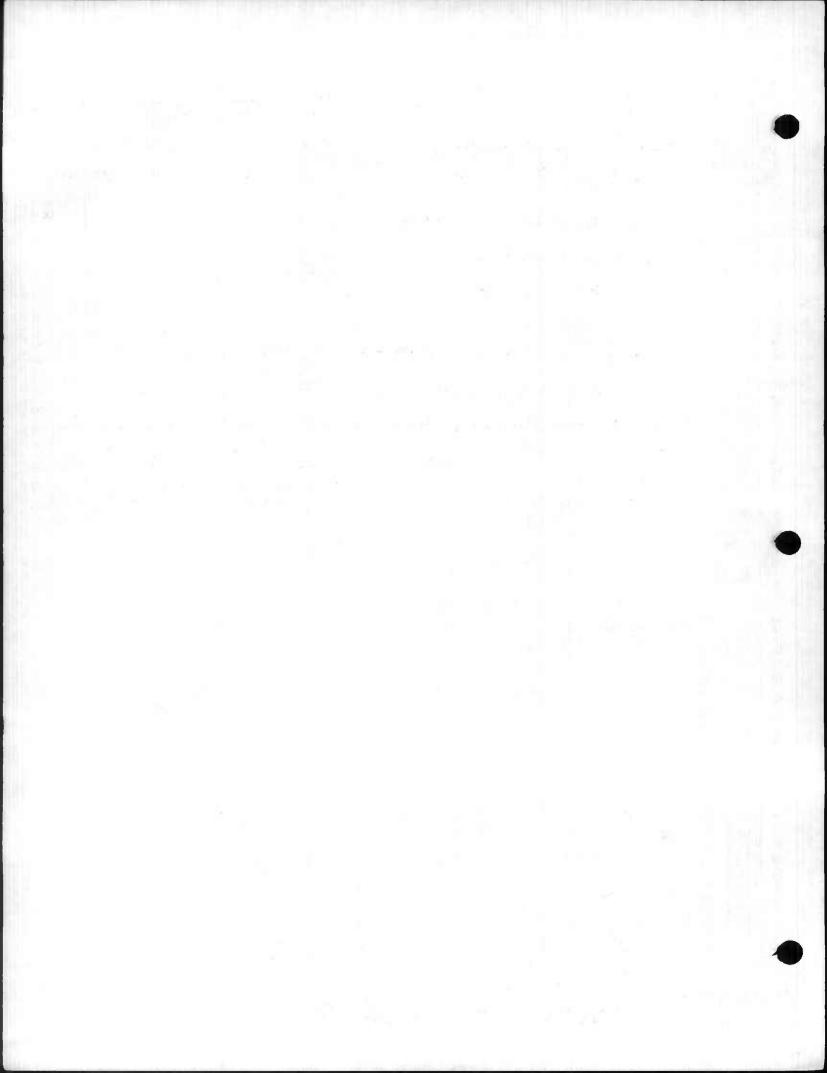
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) To the To the To the F 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TH GREEN ST. IAR 31. Date filed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

JUL 0 2 1999

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Time of Death Kenneth Eugene
48 Fecility Neme (If not institution, give street and number) 3:57 PM Shives, Jr. June 4b. City, Town, or Location of Death 4c. County of Deal Bultimore City HODKINS HOSDITA Johns If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 100 M 2□ F 217-17-0548 WV Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 X Yas 2 □ No Washington Hancock 10s. Streat and Number 10f. Zio Code 10g, Citizen of What Country? 253 North Pennsylvania Avenue 21750 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status Bleck, Whita, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Merried 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Trailer Elementery/Secondary (0-12) College (1-4or 5+) Assembler Manufacture 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Kenneth Eugene Shives, Sr. Dixie L. Patton 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dixie L. Miller/Mother 253 N. PA. Ave. Hancock, MD 21750 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Dete 1 X Burial 2 Cremetion 3 Removel from State 4 ☐ Bonstion 5 ☐ Other (Specify) Pleasant Grove Cemetery 6/29/99 Needmore, PA 22. Name end Address of Facility 21 Signature of Fueriral Service Lices Grove Funeral Home, P.A. 141 W. Main St. Hancock, MD 21750-0368 23a. Part1. Enter the disease, or complications that coused the death. Do not enter tha mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediete Causa (Finel disease or condition resulting in death) Diffuse Alveolar Hemorrhage Days hrombotic microansopath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) 2 weeks Fyngal preumonia Due to (or es a consequence of): 1 month Some marrow transplant Alloreneic Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown lymphouthe leukemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? failure, Liver failure 1. Yes 2 No 20 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Deeth (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed by

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**Funeral** 

Director

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Hygiene.

Pages 1 and 2 should be filed vitment of Health and Mental Hygis
tant: If Nem 27 is marked other 6
jury or other traumatic event, ID

filed within 72 hours after

altimore, Maryland 21215-0020

Examiner

py Be Completed

1 Neturel

3 Suicide

31. Data filed (Month, Day, Year)

29e. Certifie

Physician/Medical edicai Certification: To

The lew requires that the death certificate be executed this certificate or Attending Physician: After efter death. filled in by • Funeral C Hospital

Division of Vital Records, P.O. Box 68760 To the To the F

State Registrar DHMH 16 Rev 6/95

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture end titla of certifier 29c. License number 29d. Date signed (Month, Day, Year)

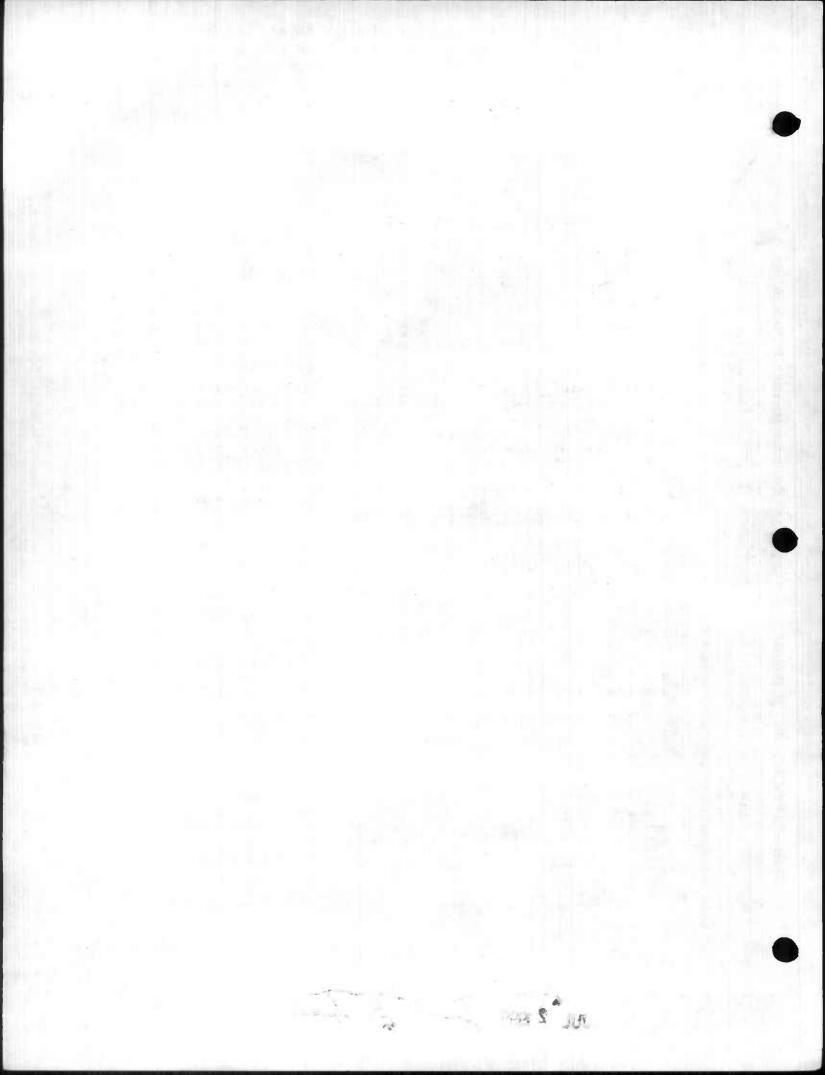
32. Registrar Signature

RES-000

June 25, 1999

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Johns Arg Hopkins

more mD

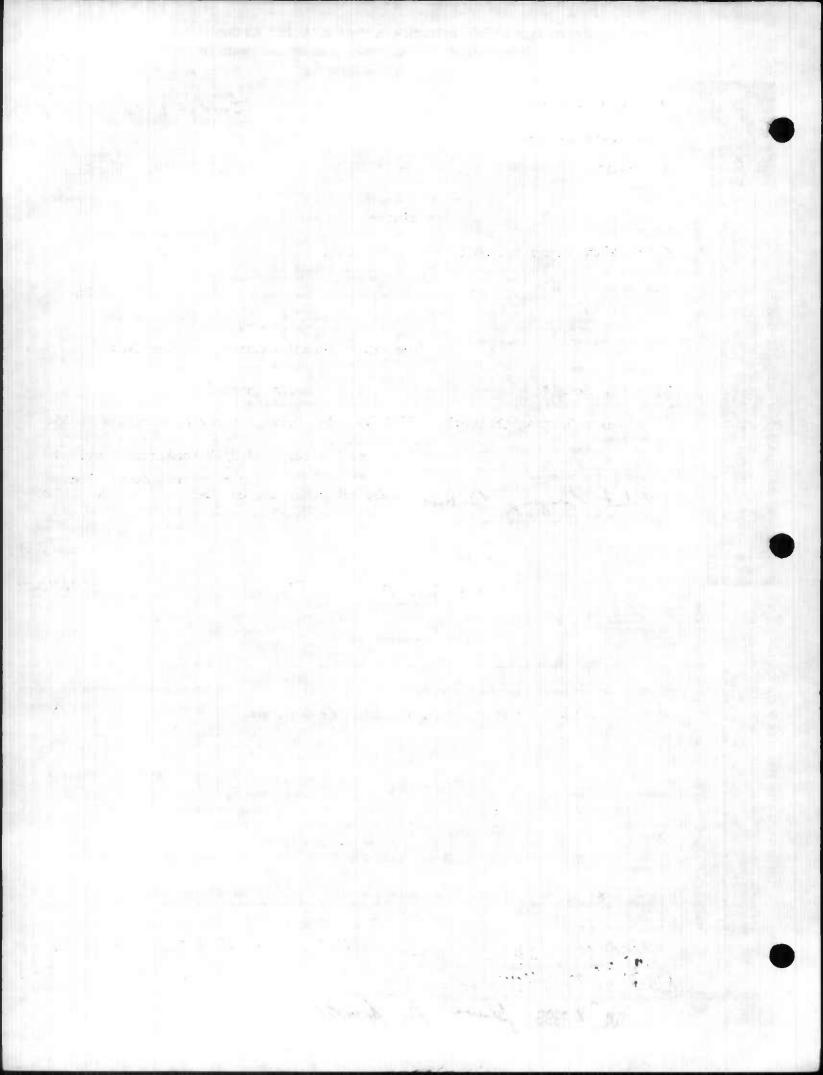


Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month Dev **Physician** Dorothy E. Schmidt 29 June /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Memorial Hospital Baltimore If Under 24 Hrs. Hours Min. If Under 1 Year 8. Dete of Birth (Month, Day, Year) Oct. 20, 1914 5. Social Security Number 7. Age (In yrs. last birthday) 9 Birthplace (State or Foreign **Funeral** Maryland 1□M 2 F Months Deys 214-40-5430 84 Director Usuel Residence of Deceden with the Maryland 10c. City, Town or Location 10a State permit. Pegas 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, tra Medical Examins: must be notified at 10b. County 10d, inside City Limits 1 N Yes 2 No MD Director Baltimore 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 830 W. 40th Street Apt 2010 21211 U.S.A. Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 XNo if Yes, Give 14. Race - American indian, Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0020 1 Yes 2 X No Specify: Specify py 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Eiementery/Secondery (0-12) College (1-4or 5+) Elementary School Teacher Education 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Walter L. Schmidt Selma Loechel 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) E. Gwendolyn Hartong (Friend) 10126 Donleigh Drive, Columbia, Maryland 21046 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ⊠ Buriei 2 ☐ Cremetion 3 ☐ Removei from Stete 7/2/99 Woodlawn, Maryland Lorraine Park Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21 Signature of Funeral Service Licensee 1630 Edmondson Avenue, Catonsville, MD 21228 23e. Pert1. Enter the disease, or combinations het caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Examiner buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest and ue to (or es e consequence of) that the death certificate be axed Records, P.O. Box 68760 physician Physician/Medical the Due to (or es a consequence of). esn Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown od by Artherosclosis Cardio Vescular þ Sign 24b. Were autopsy lindings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? Completed 2 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physicien: funeral director 25. Wes case referred to medicel examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpetient 3 DOA P this 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Neturel 2 Accident after deeth. Director: Aft 1 Yes 2 No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of injury - At home, ferm, street, fectory, office building, etc. (Specify) Hospital of 24 hours a
 Funeral D 29e. Certifier 1 🗷 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the cause(s) end menner es stated. Medical (Check only one) 2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and piece, and due to the cause(s) end manner steted. To the Vithin 2 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2438946 June 29, 1999 30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) 20/ E. University plany Union Memorial Hospital

State Registrar 31. Dete filed (Month, Day, Year)

32. Registrer's Signature



State of Maryland / Department of Health and Mental Hygiene Q

	Certificate of Death	h Reg. No.	21001			
Dhomining	Decedent's Nama (First, Middla, Last)	2. Data of Death Month Day Year	3. Time of Death			
Physician /Medical	Emma Sears	June 29, 1999	8:00 am			
Examiner		4b. City, Town, or Location of Death 4c. County of Deeth				
52.		lumbia Howard				
Funeral Director	5. Social Sacurity Number 212-03-6081 6. Sex 10 Months 1	er 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Bir (Month, Day, Year) 7. Peb. 12, 1909 Man	ithplace (State or Foreign Country) rvland			
9	Usuel Rasidance of Decedant					
how	10a. Stata 10b. County 10c. City, Town or Location		10d. fnside City Limits			
cto de cto	MD Howard Columbia		1 ☐ Yes 2 ☐ No			
in the state of th	10e. Street and Number 10f. Zip Code	10g. Citizen of What C	ountry?			
23a 23a	6500 Freetown Road Apt 108 21044	U.S.A.				
21215-0020 d within 72 hours after death with the Maryland plene. or than "natural", or items 23s or 28s-f show, the Medical Erroline metro modified.	1 Yas, Give 1 Yas 2 No Specific Year or Datas:					
72 ho	15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind of Business	s/industry			
T 5 1	(Specify only highast grada completed) (Giva kind of work done during media. DO NOT use retired)  Elementary/Secondary (0-12) Collega (1-4or 5+)	ost of working				
Maria Po	10 Supervisor	Telephone	e Company			
nd 2	17. Fathar's Nema (First, Middle, Last) 18. Mot	her's Neme (First, Middle, Maiden Sumama)				
Maryland 212: d 2 should be filed within the and Mentel Hygiene. T is marked other than traumatic avent, the M To Be Comp	Frederick W. Engel	Emelia Dudek				
~ 0 = 2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Num	Zip Code)				
other tr	Leonard H. Engel (Nephew) 5104 Hamilton Str	reet, Baltimore, MD 21	1207			
	20a. Method of Disposition  1 Burial 2 Cramation 3 Removel from Stete	Data 20c. Location - City or	r Town, Stata			
Pages nent of limit: If its	4 Donation 5 Other (Specify) Loudon Park Cemetery	7/2/99 Baltimore,	Maryland			
Baltimo permit. Page Department of Important: If any Injury or page.	21. Signeture of Funaral Sarvice Licensee 22. Nema and Address of Fac		s, Inc.			
	23a. Part1. Enter the disassa, or complications that caused the deeth. Do not enter the mode of dying, such a shock, or haart failura. List only one cause on each line.		Approximete			
Physician /Medical Examiner	Immediata Causa (Finel disaasa or condition		fritervel Between Onset and Death			
	rasulting in deeth)  Due to (or es a consequence of):		1			
e is	b		1			
68 7 60, illicate be executed g physician and as the bural-transit	Sequentially list conditions, if any, laading to immadiate cause. Enter Undarkying Ceuse (Disease or injury c.					
- U (I)	Dua to (or as a consequence of):					
.O. BOX the death cent y the attendin sched for use hysician/N	d		1			
O. E. dea	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Per	rt I. 23b. Did tobacco use contribut	te to the cause of death?			
J H H H E	Advanced dementia	1□ Yes 2√No 3□5	Probably 4 Unknown			
COLD requir been s should		24a. Was an autopsy performed?	. Were sutopsy findings available prior to completion of cause of death?			
The lever the le		1 Yas 20 No	1 ☐ Yes 2 ☐ No			
sician: The certificata lirector, pag	25. Was case reterred to medical 26. Pie	ice of Death (Check only one)				
	axaminar? Hospital: Other:	Nursing Home 5 Residence 6 Other (Sp.	vecity)			
0 = = =	27. Magnar of Death 28a. Dete of Injury 28b. Time of 28c. Injury at	28d. Describe how injury occurred				
Attending or death.  ctor: After by the fune fill cation	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Year 2 (	□No				
DIVISION ( but or Attending P is after death.  al Director: Aftert led in by the funer  Certification:	3 Suicida 6 Could not be detarmined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)	28f. Location (Street and Number or F City or Town, Stata)	Rural Routa Number,			
DIVISION To the Hospital or Attanding R within 24 hours after death. To the Funeral Director: After completely filled in by the funer Medical Certification:	29a. Certifiar (Check only one)  1 Certifying Physician: To tha best of my knowledge, daeth occurred at tha time, data of my knowledge, daeth occurred at tha time, data of my knowledge, daeth occurred at tha time, data of my knowledge, daeth occurred at tha time, data of my knowledge, daeth occurred at tha time, data of my knowledge, daeth occurred at tha time, data of my knowledge, daeth occurred at tha time, data of my knowledge, daeth occurred at tha time, data of my knowledge, daeth occurred at tha time, data of my knowledge, daeth occurred at tha time, data of my knowledge, daeth occurred at tha time, data of my knowledge, daeth occurred at tha time, data of my knowledge, daeth occurred at tha time, data of my knowledge, daeth occurred at tha time, data of my knowledge, daeth occurred at tha time, data of my knowledge, daeth occurred at tha time, data of my knowledge, daeth occurred at tha time, data of my knowledge, daeth occurred at the time, data of my knowledge, daeth occurred at the time, data of my knowledge, daeth occurred at the time, data of my knowledge, daeth occurred at the time, data of my knowledge, daeth occurred at the time, data of my knowledge, daeth occurred at the time, data of my knowledge, daeth occurred at the time, data of my knowledge, daeth occurred at the time, data of my knowledge, daeth occurred at the time, data of my knowledge, daeth occurred at the time, data of my knowledge, daeth occurred at the time, data of my knowledge, daeth occurred at the time, data of my knowledge, daeth occurred at the time, data of my knowledge, daeth occurred at the time, data of my knowledge, daeth occurred at the time, data of my knowledge, daeth occurred at the time, data of my knowledge, daeth occurred at the time, data of my knowledge, daeth occurred at the time, data occurred at	and place, and dua to the cause(s) and mennar a sath occurred at the time, date and place, and de	as stated. ue to the cause(s)			
To the To the comp	29b. Signature and title of certifier 29c. License number	r 29d. Date signed (Mon	nth, Day, Year)			
	Das Das And Will Dass	09 6/29/5	19			
	30 Name and addrass of person who completed cause of death (Item 23e) (Type, Print)					
	BARDARA Socha 1120 N. Polling Rd.	BAHTMORE, MD 21	228			
State	31. Dete filed (Month, Day, Year) 32. Registrar's Signature					

T. Out is

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Day **Physician** Peter William Sowers 1999 0350 Feb. 27 /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Yaar If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Months Days N/A 1₩ 2□ F Director 29 27. 1999 Maryland Usual Rasidence of Decedant death with the Maryland 10a. Stata 10b. County 10c City Town or Location 10d. Inside City Limits show Maryland Prince Georges Bowie XSYas 2 □ No Director 288-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 15401 Mount Oak Rd. 20716 United States Funeral or Nems 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, atc. filed within 72 hours after 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 21215-0020 1 Yas 2 No Specify: Specify: White by 3 Widowed 4 Divorced natural. Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) Coilega (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Heelth and Mentel Hygien,
Important: If New 27 is marked other that
any Injury or other traumeth. N/A N/A 17. Fathar's Nama (First, Middla, Last) 18 Mother's Name (First Middle Maiden Sumama) John Michael Sowers Donna Marie Goldsmith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Donna Sowers 15401 Mount Oak Rd. Bowie Maryland 20716 20b. Place of Disposition (Nama of camatary, crematory or other place) March 9, Date 999 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Buriai 2 Cramation 3 Ramoval from Stata
4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria Virginia 21. Signature of Funarai Sarvice Licensee 22. Nama and Addrass of Facility Robert E. Evans Funeral Home, Inc. 23a. Part f. Enter the disease, or complication that caused the death. Do not enter the mode of dying, furnish cardiac or respiratory arrest, array land 20715, and shock, or heart failure. List only one division and the caused the death. Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Final TWO WECK disaasa or condition rasulting in daath) Examiner Examiner or Attending Physicism: The law requires that the deeth certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): and ALRUBTION P.O. Box 68760 ACENTAL Physician/Medicai MIN Part fl. Other algniffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of causa of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No certificate funeral director, Be 25. Was casa raferred to medical examinar? 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 □ No Medicai Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending invastigation 1 Naturai 2 Accident s after decast al Director: After 1 Yas 2 No 6 Could not be detarmined 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledga, daath occurred at the time, date and place, and dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. 29a. Certifier 29b. Signatura and titla of certifian 29c. License number 29d. Data signed (Month, Day, Year) D 35004 JUDITH A-30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) BLUD. ARYLAND ICESEPRCH ROCKVILLE 00

**DHMH 16 Rev 6/95** 

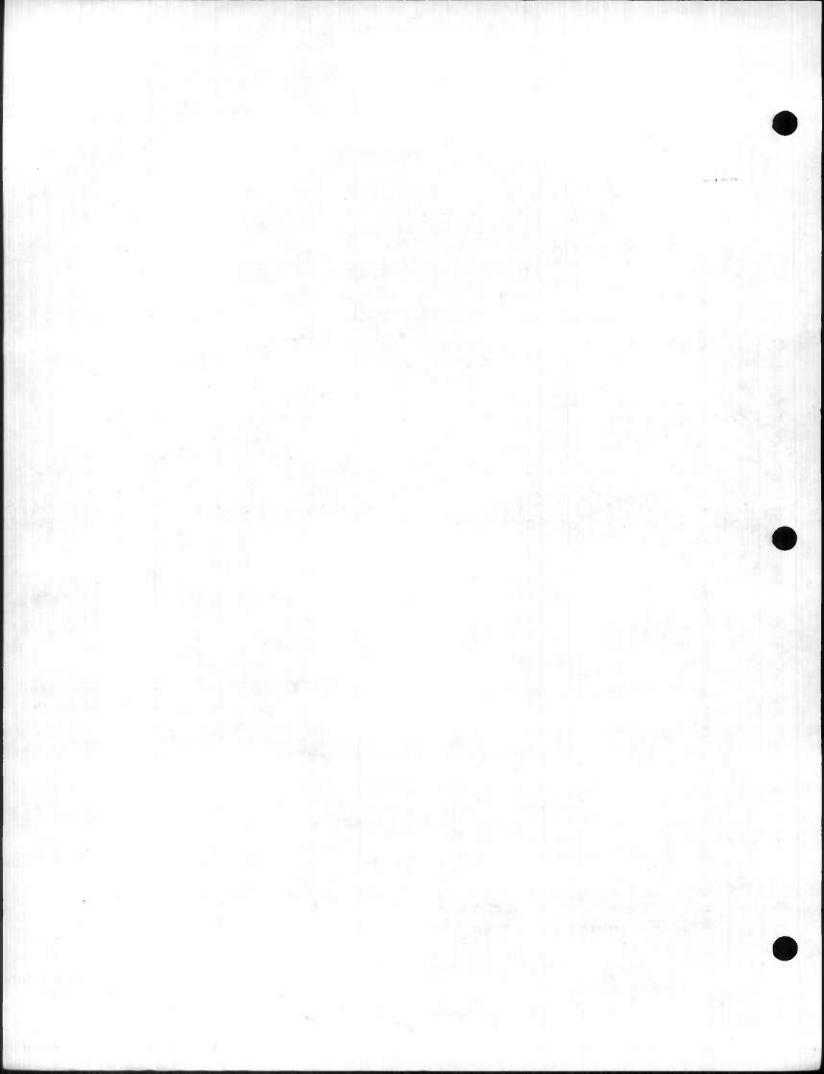
State

Registrar

31. Data filed (Month, Day, Year)

JUL 0 2 1999

32. Registrar's Signatura



Division of Vital Attending Physician: e Hospital or Attend n 24 hours after death e Funeral Diractor: A within 2

6 Could not be determined 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

1 ☐ Yes 2 No

1999

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner as stated.

Medical Examine: On the best of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) and menner stated. 29e. Certifier (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Data signad (Month, Dev. Year)

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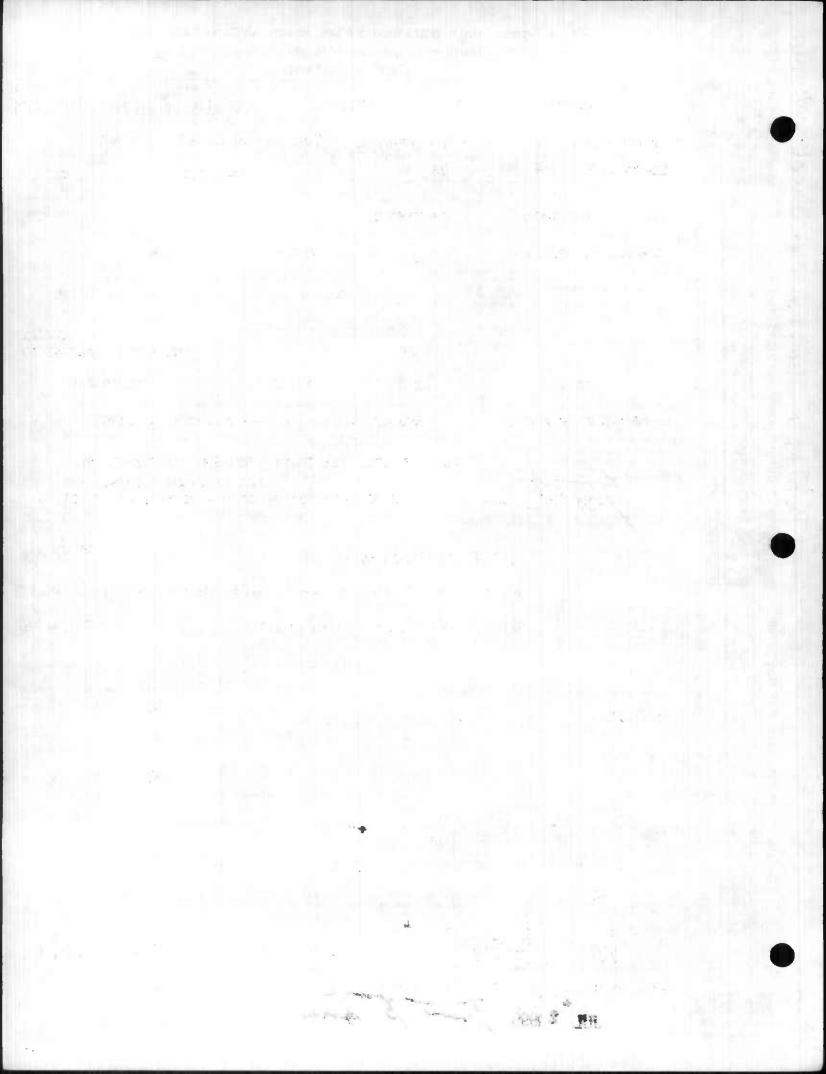
dress of person wholeomore death (Item 23a) (Type, Print) 2401 BELVEDERE AVE BALTIMORE, MD 2/2/5

CUONG HA, MD, SINAL HOSPITAL OF BALTIMORE

**DHMH 16 Rev 6/95** 

edicai

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#11 perFH G773 7/26/99 FW 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Month Day 9 AM **Physician** Mildred V. Weitzell June 28, 1999 /Medical 4a Fscility Nema (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 3642 Beech Avenue Baltimore If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (fn yrs. last birthday) Birthpleca (State or Foreign Country) **Funeral** Days 1 M 2 F YES Director 215-07-6399 80 Aug. 8, 1918 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Insida City Limits 28a-f ahow e filed within 72 hours after death with the Meryla al Hygiene. other than "natural", or Nerna 23a or 28a-f show vent, its Medical Estamble mest be notited 1 ¥ Yes 2 □ No Maryland N/A Baltimore 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? O 3642 Beech Avenue 21211 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus 14. Race - Amarican Indien, Bleck, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Datas: 1 ☐ Never Merried 2 ☐ Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 Widowed Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Packer Plastic Manufacturing 8 permit. Pages 1 and 2 should be flit Department of Heelth and Mental Hy Important: If Nem 27 Is marked ofth eny Injury or other traumatic event Pates. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be George Yeager 2 Hilda Harper 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 3642 Beech Avenue, Baltimore, Maryland 21211 Hilda Weitzell Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

√XBurial 2 ☐ Cremation 3 ☐ Removel from State Dete 20c. Location - City or Town, Stata 4 Donation 5 Other (Specify) Mt. Zion Cemetery 7/1/99 Freeland, Maryland 22. Nama and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21. Signature of Funeral Service License Falls Road, Baltimore, Maryland 23a. Pert1. En if the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or leart feilure. List only one cause on each line. Interval Between Onset and Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Examin physicien end the burlai-transit that the death certificate be assouted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Physician/Medical to (or as a consequence of): for use as P.O. Pert It, Other cant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown þ Records, 6.0 The law requires 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy parformed? 1 Yes 2 No 1 Yas 2 No Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation efter death. Director: Af 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Certifie (Check only one) within 2 ŝ 29b. Signatura and titla of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Ifem 23a) (Type, Print) 3 CT ST. Batto MD 21211 SIMON-BELTRAN, MD 105 1ADEMA State Registrar

MAG

JUL 0 8 1983 July - See 2 July

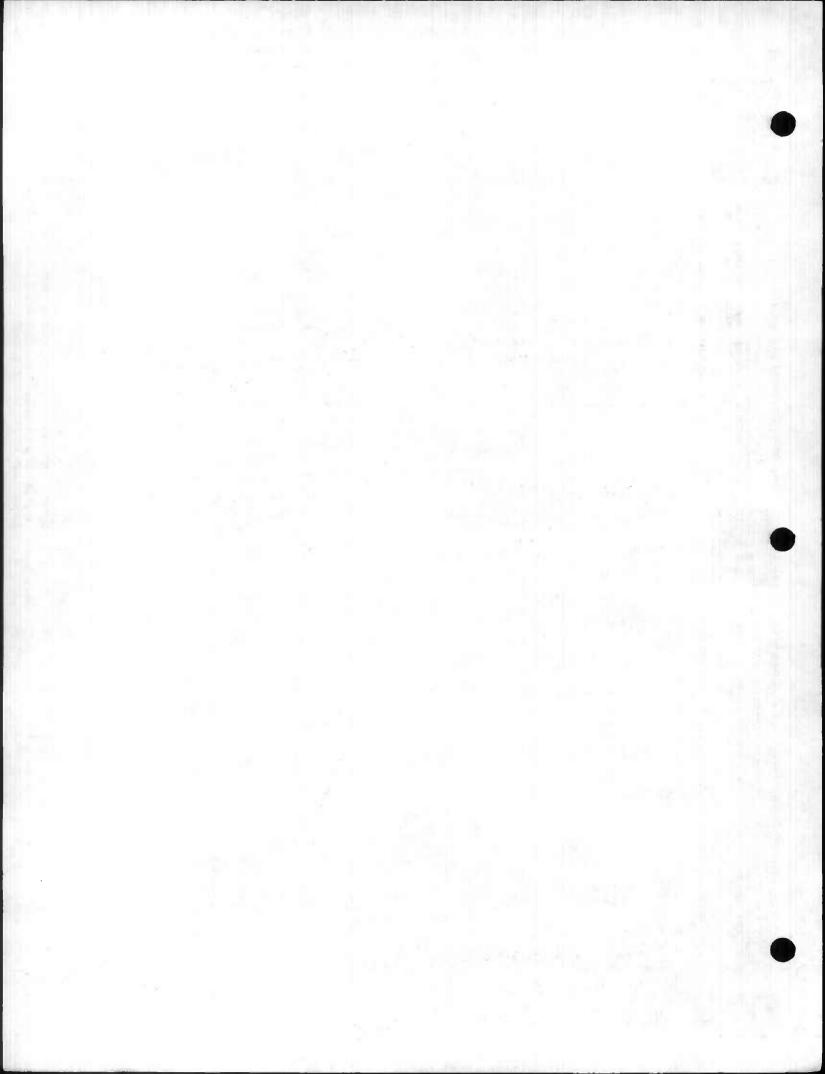
State of Maryland / Department of Health and Mental Hygiene 99 2 1 0 6

							Certi	ificate of	Death		Reg. No.	22	21001	
	Dharalala	_	ecedent's Name (	First, Middle, Las	st)					2. Data of De Month	eath Dey	Year	3. Tima of Death	
	Physiciai /Medica			Ka	therine	Weinb	erg			JUNE	29,	1999	12:45 AM	
	Examine	r 4a l		_	a street and number					or Location of Deat	h 4c.	County of Death		
					scent &				Balti				imore	
ı	Funeral Director	2	ocial Security Num	615 1	ax 7. A	ga (In yrs. last t		Months Days		Ain. 8. Data of Bir (Month, Da AUG 7	th y, Year) 190	9. Birth Cour Mar	place (State or Foreign intry) yland	
	pue *	-	al Rasidence of De Stata 1	ocedant Ob. County		10c. City, To	wn or Local	tion				1	10d. Inside City Limits	
	8e-f aho	ector	MD	Baltim	ore	Ва	ltimo							
	after death with the Marylen or Nema 23a or 28a-f show infret mast be notified at	7	920 Sco	-	vel Road	d			1208			ten of What Coul		
0 5 -1 0		2	11. Marital Status  1 Nevar Married 2 Merried 3 Widowed 4 Divorced  12. Was Decedent Evar in U,S. Armed Forcas? 1 Yes 2 No If Yas, Giva Year or Detes:				as Decedent of it as, specify Cub		(Specify Yas or No uerto Rican, atc.)	10	14. Race · American Indien, Black, Whita, atc. Specify: White			
15-0	in 72 hours	EI 17. I	15. Decedent's Education (Specify only highest grade completed)					nt's Usual Occup nd of work dona NOT use retire	pation during most of ad)	working	16b. Kir	nd of Business/In	dustry	
212	s within jiene. Then	E E	lementary/Second	ary (0-12)	Collega (1-4or	Homemaker					0	wn Home	e	
	be filed d other event, to	17.1	Fathar's Name (Fil	rst, Middle, Last)		· ·			18. Mother's	Nama (First, Middle	, Maiden .	Sumama)		
/lar	should be nd Mental marked o	0	Isa	ac Lag	owitz					Anna Ur	nk.			
Maryland	and I		. Informant's Name	e/Relationship (7	Type, Print)	19	9b. Mailing	Address (Stree	t and Number of	Rural Routa Numb	er, City or	Town, State, Zit	p Code)	
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Baltimore,	Pages 1 an nent of Heel nt: If Item 2 iry or other		Mathod of Dispos 1 ☐ Burial 2 ☐X		Removel from State			ion (Nama of tory or othar pla		Data		cation - City or To		
ti m		-	4 Donation 5	Othar (Specif)	1)	Metr			Inc. 6			timore,	MD	
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8		238	. Part1. Enter the shock, or heart f	disaasa, or compaitura. List only	plications that cause one cause on aach	d tha death. De	o not enter	tha moda of dy	ing, such as can	diac or respiratory a	rrest,		Approximata Interval Between	
	Physician				AAL.						/		Onset and Death	
	/Medical Examiner	disa	nediata Cause (Fir lass or condition ulting in death)	nal	MYOG	AR DIG	H_	INF	FARC	710N		IMME	SUPTIE	
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ó	ufficate be executed g physician and as the burial-transit	Seq if ar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying											
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	ing ph as th	E last	ulting in death) Las	"										
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o.	ires that the death cer signed by the attendin d be detached for use	Part	Part II. Other algorificant conditions contributing to death but not resulting in					erlying causa gi	iven in Part f.	id tobacco use contribute to the cause of death?				
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CO	> 11 00 m	Complete								_ perf	ormed?	CC	vailable prior to ompletion of ceuse f death?	
	certificate has be rector, page 2 s	5								10	Yas 2		☐ Yas 2☐ No	
	elan: T	25.	Was casa rafarrag	to medical					26. Place of	Death (Check only			2,40 12.10	
<u>&gt;</u>	Physician: this certificatal director.		axaminar?		Hospital:	ient 2 ER/0	Outpatient	3 DOA Ot	hor:	ig Homa 5 ☐ Ras		Othar (Speci	ity)	
	After this funeral di		Manner of Death	5 Panding	28a. Data of Inj (Month, D	ury 28b	. Tima of Injury	28c. Inju	ry at ork?	28d. Dascribe	how Injur	occurred		
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Division	is or Attending P is after deeth.  al Director: After to de in by the funera		3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	26a. Place of In	ijury - At home, tc. (Specify)	farm, stree	t, factory, office		28f. Location ( City or To	(Street and wn, State,	d Number or Run	ral Routa Number,	
	pital grass		. Certifier 1	Scaribina Dh	valeton. To the boot	of my bounded	an death a	annead at the t	ina data and al	han and due to the			stated	
	To the Hospital or Attending Physician: The is within 24 hours after deeth.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page and after a funeral director.	2 294			ysicfan: To the best niner: On the basis of and mannar s	of axamination a								
	vithin Fo th compl		Signatura and titl	a of certifier				29c. Lican	sa number		29d. Dat	a signed (Month,	, Day, Year)	
			the Sanda MO 11940 JUNE 20 1999									7 1999		
		30.1	Nama and addrass	of person who	completed causa of	death (Item 23s	) (Type, Pri	int)	111.	0	1	- 07	10	
	52.61		IAN	SUNS	HINE	,MP	6	710/	K-Hts	. He	15A	UT, M	102/215	
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DHMH 16 Rav 6/95

ORIGINAL



99-3705-031 jhm DONNA WILLIAMS ITEMS: #23 PART I, 27 PER MEO G773 7-12-99 Certificate of Death 1. Decedeni's Name (First, Middle, Last) **Physician** Donna Williams /Medical 4a Facility Neme (If not institution, give street and number) Examiner TREE TOP DRIVE If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1□ M 20 F 36 Yes 116-66-3098 Director Usual Residence of Decedent death with the Maryland Show 10b. County 10c. City, Town or Location alt, or items 23a or 28a-f show Director Montgomery Silver Spring 10e Street and Number 10f. Zip Code 12305 Tree Top Drive, Apt. 34 20904 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? filed within 72 hours after 1 Never Merried 2 Merried 1 Yes 2 No 21215-0020 "netural", or 1 Yes 2 XNo Specify: þ 3 Widowed 4 Divorced Year or Detes Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) ith and Mental Hygiene. 27 ie merked other than \*r r traumetic event, pr. Med Elementery/Secondary (0-12) Cotlege (1-4or 5+) 5+ Baltimore, Maryland 17. Father's Neme (First, Middle, Last) Be Pages 1 and 2 should be in ent of Health and Mental Int: If Nem 27 is marked of Rainford Williams 19e. Informant's Neme/Reletionship (Type, Print) Norma Williams - mother item 2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2. Date of Death 3. Time of Death 4b. City, Town, or Location of Death 4c. County of Death 09:50 AM ILVER SPRING MONTGOMERY 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 10. England 10d. Inside City Limits 1 Yes 2√ No 10g. Citizen of What Country? USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: black 16b. Kind of Business/Industry Aeronautical/Mechanical Engineer Engineering 18. Mother's Name (First, Middle, Maiden Surname) Norma Donaldson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 97 Wellington St., Hempstead, N. Y. 11550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 XBurial 2 ☐ Cramation 3 ☐ Ramovel from Stele 03/99 4 □ Donetion 5 □ Other (Specify) Pinelawn Memorial Park Pinelawn, N. Y. 22. Name and Address of Facility
Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 21. Signeture of Funerel Sarvice Ligensee u 7250 Washington Blvd., Elkridge, Md. 234 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Betw Onset end Death tmmediete Ceuse (Finel disease or condition resulting in deeth) HYPERTENSIVE CARDIOVASCULAR DISEASE Due to (or as a consequence of) Examiner Sequentiatly list conditions, if any, leading to immediate cause. Enter Undarfying Cause (Disease or Injury that initiated events resulting in death) Last Due to for as a consequence of) Physician/Medical Due to (or as a consequence of): 23b. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed 2 1 No 1 Yes 2 No 25. Was case referred to medical examiner?

YE Yes 2 No Be 26. Place of Death (Check only one) To Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Dete of tnjury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 28c. Injury at Work? 1XX Netural 5 Pending Investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 T Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Simulare and little of certifier OCME JUNE 30, 1999 w

State Registrar

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Department of Important: If eny injury or DOGS.

**Physician** 

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page 2

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To the Hospital within 24 hours a To the Funeral Completely filled

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Neme and address of person who

KID OLD MOD

31. Date filed (Month, Day, Year)

Box 68760.

P.O.

Records,

Division of Vital

The law requires that the death

/Medical

**DHMH 16 Rev 6/95** 

**ORIGINAL** 

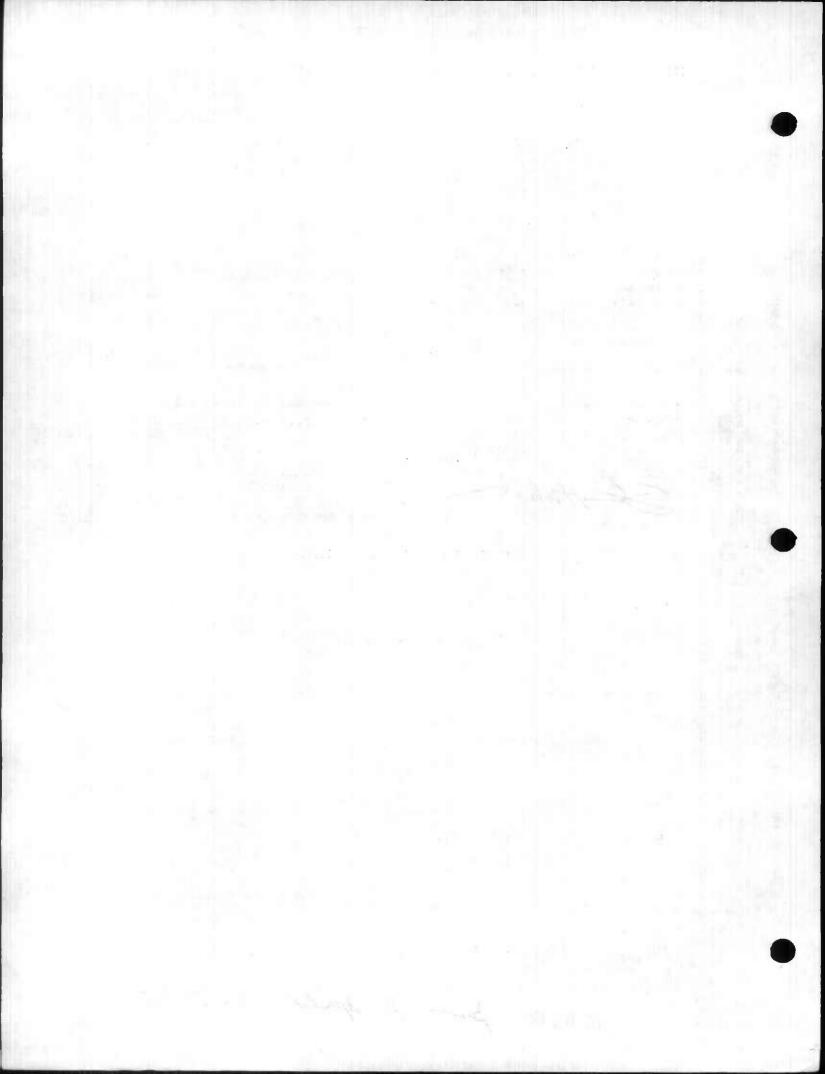
Baltimore, Maryland 21201

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

111

KONTU Min



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedant's Nema (First, Middle, Last) 2. Data of Deeth 3. Time of Death Mildred **Physician** Warm 7:35 m June /Medical 4a. Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Z700 N. Chorles St. Futurecare Homewood Raltimore ff Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day 5. Sociel Security Number 6. Sax 9. Birthplace (Stata or Foreign Coupter) Carolina **Funeral** 1 M 2 X F Months Days 229-18-4982 Usual Rasidence of Decedant Director with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Pagas 1 and 2 should be filed within 72 hours aftar death with the Marylan nent of Haalth and Mental Hygiana.
Int: If Item 27 Is marked other than "natural", or Itema 23a or 28a-f show ary or other traumatic event, the Modical Examinations to notify a district that the notify and as 1 Yas 2 □ No Directo Maryland more 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2412 WOOd Funeral 12. Wes Decedant Evar In U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indian, Bleck, Whita, atc. 11. Maritai Status 1 Yes 2 No If Yas, Give Yeer or Datas: Navar Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No à Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedant's Usual Occupation
(Give kind of work done during most of working
life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) d 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maidan Sumame Be 2 19a. Informant'a Name/Ralationship (Type, Print) daughter) 19b. Mailling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 2438 Druid Hill Ave, Balto, Md. 2438 repleau Plece of Disposition (Nama of cematary, cremetory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition permit. Pagas Department of Important: If It any Injury or o 1 Buriai 2 □ Cramation 3 □ Removel from Stata 4 ☐ Donation 5 ☐ Othar (Specify) on ud ta 22. Name and Address of Facility 21. Signatore of Funerei Sarvice Licensee Josep W. North Enter the clease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, or heart future. List only one cause on each line. Approximate Interval Batween Onset and Deeth Physician /Medical Immediata Causa (Final disaasa or condition resulting in death) Examiner Dua to (or as a consecu Physician/Medical Examiner physician and s the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated successions) Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760, that initiated evants rasulting in death) Last Dua to (or as a consequence of): 88 attanding p for usa as signed by tha a d be detached f Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Hilknown 1 marino þ Joins 24b. Wara autopsy findings evallable prior to completion of cause of daath? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case raferred to medical examinar? Be 28. Place of Daath (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Aftar this funaral 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Dascribe how injury occurred 5 Pending investigation after death. Director: Af 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Piace of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicida hours a a Funeral 29a. Certifiar 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Hosp within 24 ho To the Fune completaly fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signetura end titla of certifier 29d. Date signed (Month, Day, Year) 31464 30. Name and addrass of person who complated causa of death (Itam 23a) (Type, Print) ENTAW St finte 308, Balt. MD 21201 HATSHMI 821 JHOA113 32. Ragistrar's Signatura 31. Data filed (Month, Dey. Year) State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth 2. Date of Deeth Month YANKELOVE 29, 1999 JUNE 0555 MIRIAM 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE TOHUS HOPKIUS HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Birthplaca (State or Foreign Country) Months 1 M 2 K F 212-12-6647 JAN. 11, 1921 MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes X No MD BALTIMORE RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3734 SPRINGDELL AVENUE 21133 U.S.A. 14. Race - American Indian 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) BENJAMIN LERNER EVA POLANSKY 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALEXANDER YANKELOVE / HUSBAND 3734 SPRINGDELL AVENUE - RANDALLSTOWN, MD 21133 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition SFARD 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) TIFERETH ISRAEL ANSHE 6/30/99 ROSEDALE, MD 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) LYMPHOMA 2 YEARS Due to (or as a consequenca of): WEEKS PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24e. Wes en autopsy 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

**Physician** /Medical Examine

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

"naturel", or items 23a or 28a-f show edical Examiner must be nothed at

permit. Peges 1 end 2 should be filed within 72 hours after death v Department of Health end Mental Hygiene. Important: If item 27 is marked other than "naturel, or items 23a any injury or other treumatic event, the Hodical Examinet must benes.

Directo

Funeral

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Completed

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Examiner physician and the bunal-transit Se 950 for page 2

certificate be executed Box 68760. signed by the a Division of Vital Records, P.O. has Hospital or Attending Physician: this funerai After aftar deet filled in by

Physician/Medical by Be 2

24 hours

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State Registrar **DHMH 16 Rev 6/95** 

Descripting Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated.

2 Madical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

1 Yes 2 No

' WD

Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

RES-000

29, 1999 JUNE

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 Could not be

1 Natural

2 Accident

3 Suicide

29a. Certifier

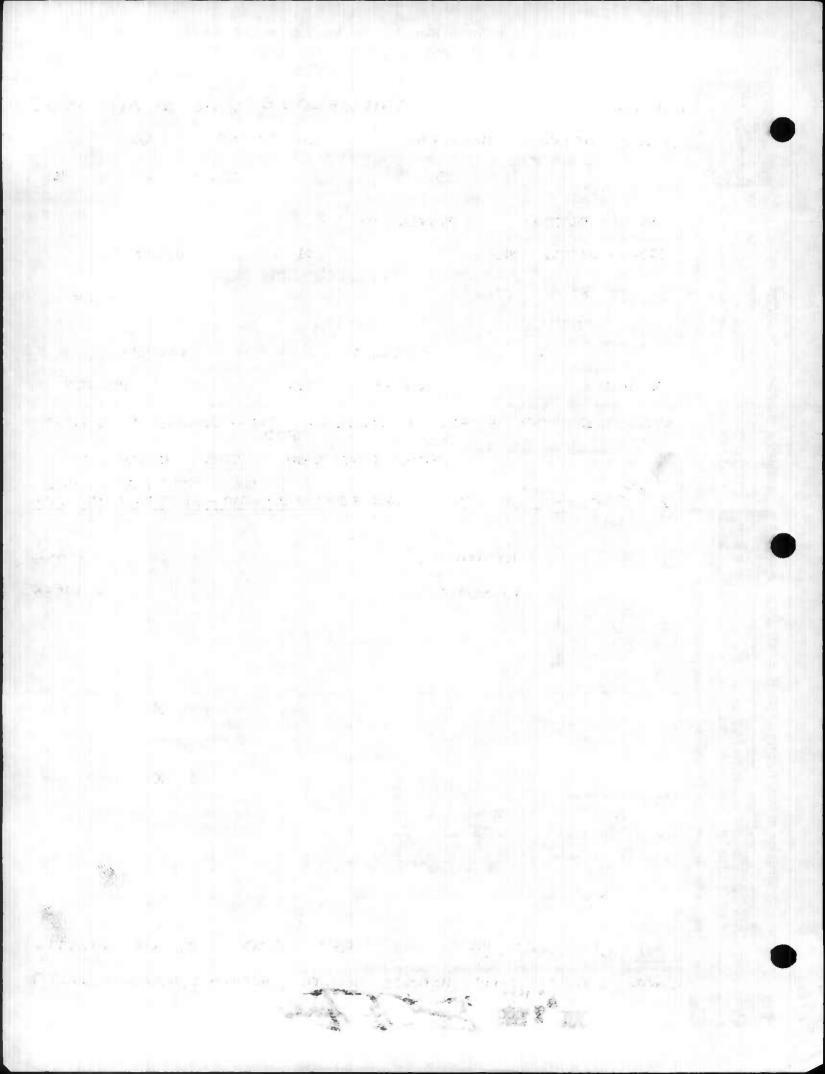
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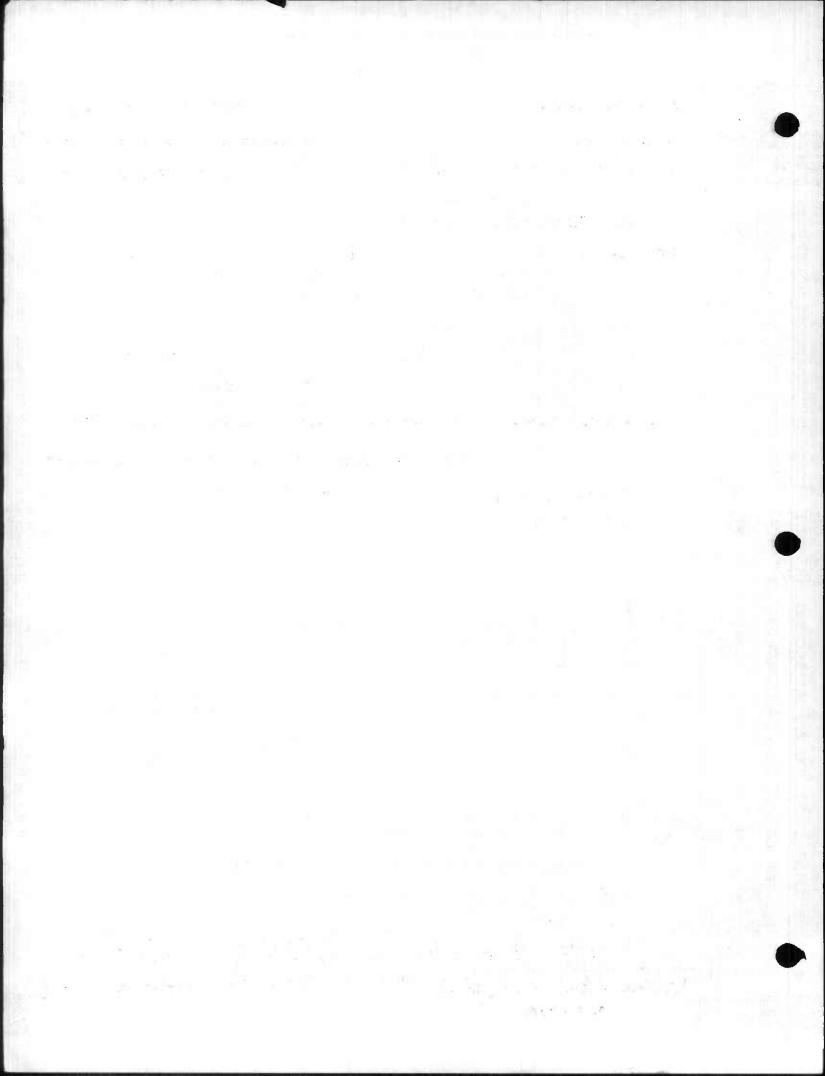
ZAAS, MD, JOHNS HOPKINS HOSPITAL, BALTIMORE, MARYLAND, 21287

32, Registrati 31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene 99 21065

						Certificate	of Death		Reg. No.		410	00
	Physic		1. Decedent's Name (First, Middle, La Naomi Pearl Adam					June		999	3. Time o	
	/Medi Examii		4a. Facility Neme (If not institution, given Homewood Nursing				4b. City, Town, or Williams		4c. County	of Death	n Coun	
8	Funeral Director		5. Social Security Number 220–16–3634  Usual Residence of Decedent	ex 7. Age ( ☐ M 2[X]F	(In yrs. lest bii	rthday) If Under 1 Y Yrs. Months Di		8. Date of Birt (Month, Da Feb. 1	y, Year) 1, 1907	9. Births Cour Man	olace (State ontry) Cyland	
	72 hours after death with the Meryland naturel; or itema 23a or 28a-f show or al Examiner, must be notified at	Director	10a. State 10b. County  Maryland Washing 10e. Street and Number	ton Co.		on or Location  cstown  10f. Zip Cod			10g. Citizan of V	What Cour		ity Limits 2 No
020	d 2 should be filed within 72 hours after death with the Merylar th and Mental Hygiene. 7 is marked other than "naturel", or frama 23a or 28a-f show treumatic event, the Medical Examiner must be notified at	by Funeral	1005 Linwood Roa  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	er In U,S.	13. Was Decedent If Yes, specify (	of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No o Ricen, etc.)	- 14. Rac	ck, White,	can Indian, atc.	
21215-0020	within 72 hou ene. than "nature	Completed	15. Decedent's E. (Specify only highest grant processes (Specify only highest grant processes (Specify Only) 12			Decedent's Usual Oc (Give kind of work de life. DO NOT use re DMEMAKET	ccupation one during most of wor tired)	king	16b. Kind of Bu		dustry	
Maryland 2	Elementary/Secondary (0-12) College (1-4or 5+) 12 17. Father's Neme (First, Middle, Last) Ray Landis Booth 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or							ne (First, Middle,				
	C = 01 -		19a. Informent's Name/Relationship ( Garrett Newton A	dams/Husban	nd 10	005 Linwood	Road, Hac	gerstown	, Maryla	and 2	21740	
Baltimore,	S 0 7 7		20a. Method of Disposition  1 □ Burial 2 □ Cremetion 3 □  4 □ Donetion 5 □ Other (Specification)	y)			rial Park J	une 21	20c. Location - Hagersto			and
Bal	permit. Pag Department Important: i any injury o			immain	_	1331 Eas	A. Fiery F tern Blvd.	, N. , Hage	erstown,	Mary	land 2	21742
No.	Physician /Medical Examiner	Examiner	23a. Pant. Enter the disease, or complete shock, or hear dailure. List only  Immediate Cause (Final diseasa or condition resulting in death)  Sequentially list conditions,	a. So. Do.	(EVE)  Je to (or as a  ) (UAT	ne Hup	HCM (D)	or respiretory er	rest,	(	Approximel Interval Bet onset and	ween
Box 68760,	death certificate be executed e attending physician and of for use as the buriel-transit	Medicai	Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last	Refu	uΥ			MUN	THE			
P.O.	the sche	by Physician/I	Pert II. Other significant conditions	entributing to death but in		the underlying cause		23b. Dld t	obacco use con Yes 2 No		the cause	
Records,	ew requires been so 2 should	Completed t	Machien	TIN				24a. Wes	en autopsy med?	av co	ere autopsy i ailable prior t impletion of d death?	to
Vital	sician: The certificate irector, pag	o Be Con	25. Was casa reterred to medical examiner?	Hospitel:	-5		26. Plece of Dee		ne)		□Yes 2□	No
Division of	or Attending after death. Director: After in by the fune	Certification: T	27. Manner of Death 1		(ear) 28b.	Time of 28c.	njury et Work? 1 Yes 2 No		now injury occurr	red		nber,
_	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of n ilner: On the bests of ex and manner stete	camination an	e, deeth occurred at the	e time, date and place ny opinion, death occu	, and due to the orred at the time, o	cause(s) and me data and place, (	enner as s and due to	tated. the cause(s	5)
	To th To th Comp	M	29b. Signeture and this of circlines 30. Name and address of person who	MCD()	A (() () () () () () () () () () () () ()	noon	ense number		29d. Date signed	d (Monter	Day, Year)	//
	Sta Registr		31. Date tiled (Month, Day, Yeer)	32. Registrar's	1 Signature	747 N	eds	Hve.	ttaes	2570	pener	the



State of Maryland / Department of Health and Mental Hygiene 99 2 1 0 6 6

			Certificate of	Death	Re	eg. No.			
Dh i a i a i a .	1. Decedent's Name (First, Middle, L	ast)	1	40	2. Data of Deat	oth Day Year			
Physician /Medical	BUNNE	J.	ANDER	SON	JUNE	10 <sup>ay</sup> 1	999	5:17	p.m.
Examiner	to Condition blooms (Money touth of our			4b. City, Town, or UBALTIMORE					
Funeral Director	5. Social Security Number 6. 329-44-9940  Usual Residence of Decedent	Sex 1 □ M 2 □ F 7. Age (In yrs. 50	Months Day:		(Month, Day,	Dete of Birth (Month, Day, Year)  JULY 9, 1948  9. Birthplace (Stete or Fo. Country)  ILLINOIS			or Foreign
Manual Ma	10a. State 10b. County	10c. City	y, Town or Location				. 1	Od. Inside C	ity Limits
or 28e-f sh be notified.	WV BERKE	LEY	MARTINSBURG						2 (XNo
# 0.8 C		Y DRIVE	10f. Zip Code 2540	1	10	0g. Citizen of V	What Coun	lry?	
Maryland 21215-0020  42 should be filed within 72 hours after death th and Mental Hygiens. T is marked other than "natural", or itsers 23 traumatic event, the Medical Examiner must.  To Be Completed by Funeral	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		ban, Mexican, Puerti	pecify Yes or No- p Rican, atc.)		e - Amaric ck, White, o		
	15. Decedent's (Specify only highest of	Education rade completed)	18a. Decedent's Usuel Occi (Give kind of work don	e during most of wor	king	16b. Kind of Bu	usiness/Inc	lustry	
	Elementary/Secondary (0-12)	College (1-4or 5+)	'life. DO NOT use retir	ed)					
Co n'interior		4	HOMEMAKER	19 Mothade Nam	ne (First, Middle, N		OME		
Mental H Mental H mrked off affic ever To Be					IILD CARL				
and showing the state of the st	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address (Street	et and Number or Ru	ral Routa Number,	City or Town,	Stata, Zip	Coda)	3 L
- 5982	MARCUS C. ANDER	SON/HUSBAND	2100 CANTER	RBERRY DRI	VE, MART	INSBURG	G, WV	2540	1
Pages 1.1 eart of He rst. If Nem rry or oth	20a. Method of Disposition  12 Burial 2 Cremation 3  4 Donation 5 Other (Spec	Removal from State	tace of Disposition (Name of emetery, cremetory or other pl LINGTON MEM. P			ROCKFOR			C
Baltimore pemil. Pages 1 s Department of He important: it lism any injury or oths ance.	21. Signature of Funeral Service Lice		22. Name and Add					31311101	
Physician /Medical Examiner	23a. Pert1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition rasulting in death)	y one cause on each line.  Sepsis  Due to (o	n. Do not entar the mode of dy	ring, such as cardiac	or respiratory arre	st,		Approximat Interval Bet Onset end	Death
BOX 68/6U, sub certificate be executed attending physician and for use as the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Lnd stage liver disease  Due to (or as a consequence of):  Cryptogenic Cirrhosis  Due to (or es a consequence of):  d.								ths
Physic	Part It. Other significant conditions	liven in Part I.	23b. Did tobacco use contribute to the cause of deat  1  Yes						
OT VITAI HECORGS, Physician: The law requires th this certificate has been signe ral director, page 2 should be in To Be Completed by					24a. Wes ar perform		ava	ore autopsy hilable prior to hipletion of co deeth?	to
ysician: The lysician: The last sertificate hidirector, page					1□ Ye	s 200	10	Yes 2	(No
certificate rector, page Co	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only on	в)			
Of VITA Physician: this certific ral director,	1 □ Yes 2 No	Hospitat: 1 Inpatient 2	ER/Outpatient 3□ DOA O	ther: 4 Nursing H	ome 5 Raside	nce 8 DOth	er (Specif)	1)	
IVISION  Attending for death.  If ector: Attending in by the fune rtification	27. Manner of Death  1 Natural 5 Pending 2 Accident 3 Suicide 6 Could not 4 Homicide detarmine	be de Disea of Inium. At he	orna, tarm, street, factory, office	Yas 2□No	28f. Location (Str. City or Town	reet and Numb		l Route Num	nber,
To the Hospital of within 24 hours a To the Funeral D completely filled Medical Ce									
Vithin To the	29b. Signature and title of certifier		29c. Licer	nse number	25	9d. Date signe	d (Month, i	Day, Year)	
	15 T.W	PHYSIC	IAN	5-000		JUNE 10, 1999			
	30. Name and address of person who	KUR, MD, JOHNS H	DEKINS HOSPITAL,		LFG STREET	BALTIN	IORE, 1	40 212	.57
State Registrar	31. Dete filed (Morith, Day, Year)  JUN 1 4 1999	22. Registrar's Signer	H. Goods	/					

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STON MEM. PARK CL

BROWN FUNERAL HOME TO BOX 821, MARTINSE.

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99

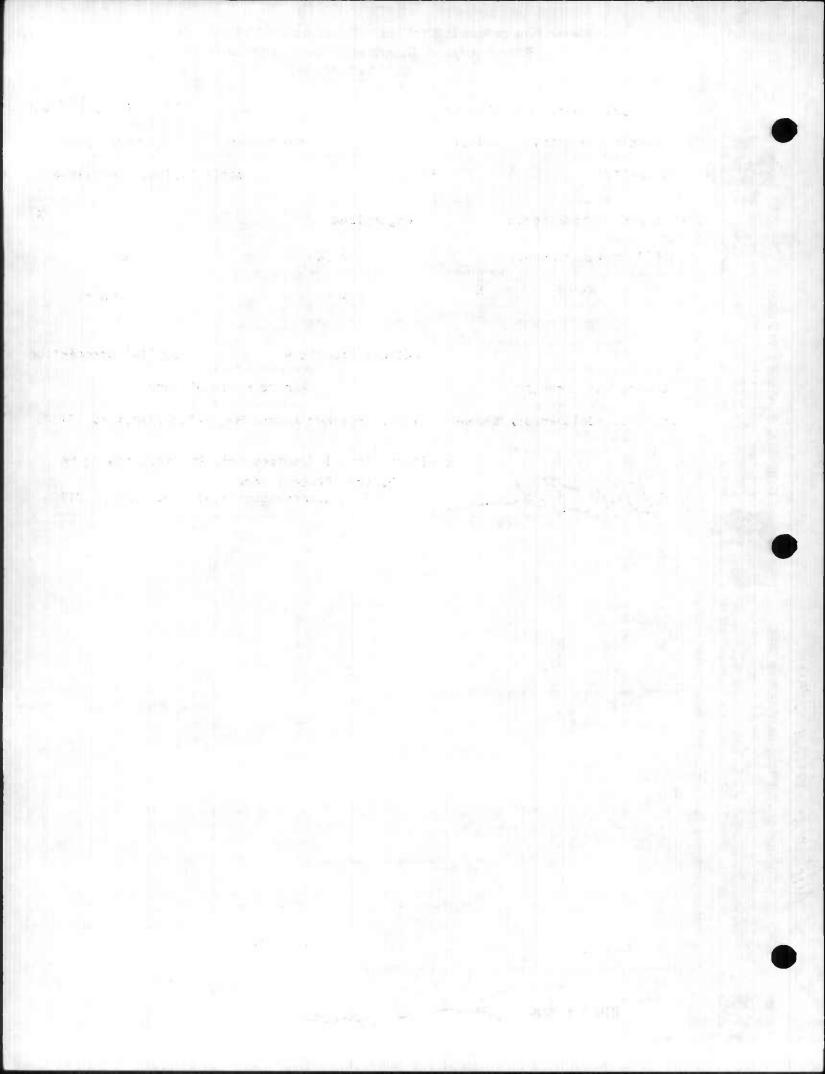
Certificate of Death 1 Decedent's Neme (First Middle Last) 2 Date of Death 3. Time of Death **Physician** 0350hrs 09 Gloria Jean Adelsberger JUNE /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown If Under 24 Hrs. Hours Min. If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2☑F Months Deys Yrs. 56 Director 160-36-3174 April 19,1943 Maryland Usuel Residence of Decedent the Meryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f ahov Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10923 Roessner Avenue permit. Pages 1 end 2 should be filed within 72 hours eftar death a Department of Health and Meniel Hygiene. Important: If item 27 is marked other than "natural", or items 23s and injury or other traumatic avent, the Medical Examiner Final PAGE. 21740 USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married XX Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: λq 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Medical Secretary Hospital Association 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Leonard Van Bernhard Martha Marie Winters 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Thomas L. Adelsberger/Husband 10923 Roessner Avenue Hagerstown, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 Burlai 2 □ Cremation 3 □ Removal from State 4 Donetion 5 Other (Specify) Tonoloway Baptist Cemetery 6-12-99 Warfordsburg, PA Osborne Funeral Home 425 S. Conococheague St. Williamsport, MD 21795 23a. Part. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Onset end Death **Physician** Immediete Cause (Finel diseese or condition resulting in death) /Medical 5 month Examiner Due to (or es a consequence of) Examiner The law requires that the death certificate be executed physicien end the burial-trensit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): 80 980 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed s certificeta has b director, page 2 s 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was cese referred to medical examiner? 28. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) n 24 hours after dea ne Funeral Directo bletaly filled in by th 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homleide edical 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) end menner es stated. To the Hosp within 24 hor To the Fune completaly fi (Check only one) 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 6.9.99 41667 Melamade MD 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) Medical Compus Rd. Suite 130 Hagerstown Michael 11110 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

**JUN 11** 

Adelsberger, Glovia Jean



State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death

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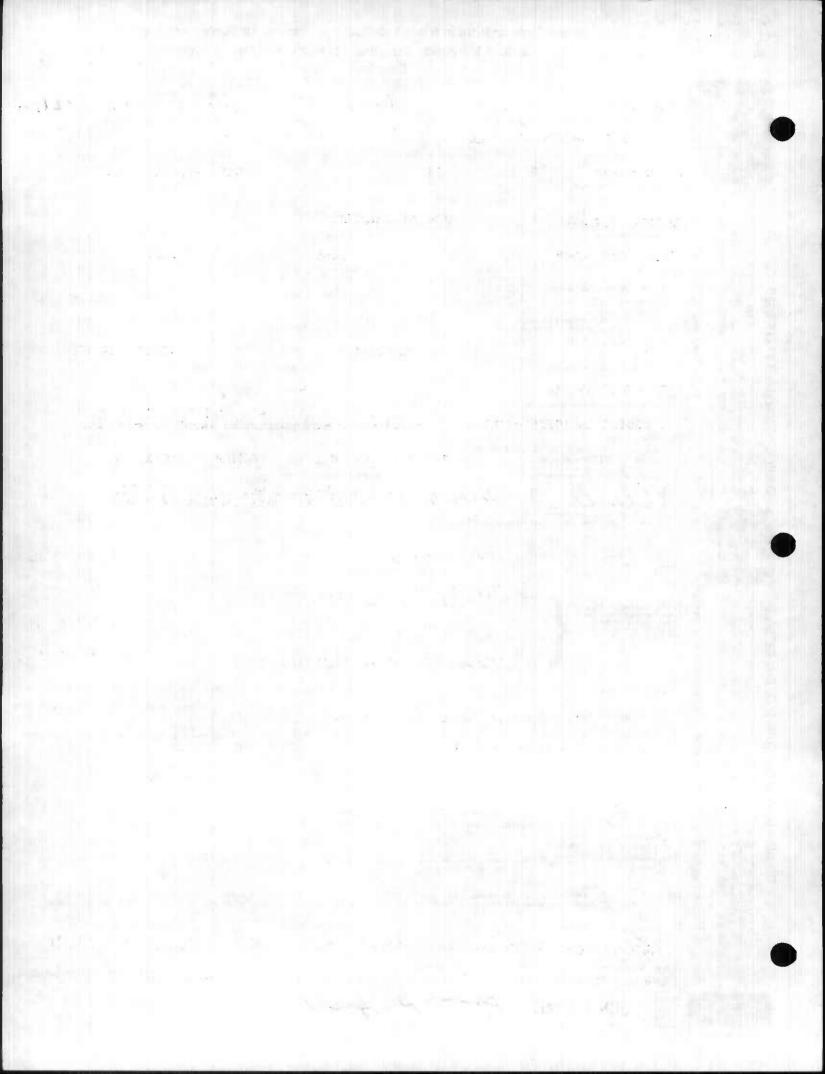
	/Med Exami
	Funeral Director
Maryland 21215-0020	nd 2 should be filled within 72 hours effer death with the Maryland. Ith and Mental Hygiene. 27 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Marked Examiner must be notified at

1. Decedent's Name (First, Middla, Last) 2. Data of Daath 3. Time of Deeth Day Yaar Month **Physician** Alexopoulos Ohristos 2:21pm JUNE 1999 ical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Undar 1 Yaar | If Under 24 Hrs. 6. Sax 1 AM 2 F 8. Data of Birth (Month, Day, Yaar) Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) Months Days Hours Yrs 375-54-4459 OCT. 11, 1927 GREECE Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No NEW PORT RICHEY FLORIDA PASCO Direct 10e. Street and Number 10g. Citizan of Whet Country? 10f. Zip Code U.S.A. 4634 IRENE LOOP 34652 Funeral 13. Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Wes Decedent Ever in U,S Armed Forcas? 14. Race - American Indian, 11 Maritel Status Bleck, Whita, atc. 1 Never Marriad 2 Married 1 ☐ Yas 2 ☐ No If Yes, Give 1 ☐ Yas 2 🖾 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decadent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collaga (1-4or 5+) CHECKER GENERAL MOTORS 18. Mothar's Nama (First, Middla, Maldan Sumame) 17 Fathar's Nama (First, Middla, Last) Be JOHN ALEXOPOULOS ELENI PANAGIOTAROPOULOS 19b. Malling Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) 4634 IRENE LOOP, NEW PORT RICHEY, FI. 3465 19e. Informent's Neme/Reletionship (Type, Print) 4634 IRENE LOOP, NEW PORT RICHEY, FL 34652 2-16 SHENANDOAU ROAD, MARTINSBURG, WV - 25401 W. LOUISE ALEXOPOULOS/WIFE permit. Pages 1 and Depertment of Health Important; If Item 27 any Injury or other t page. 20e. Mathod of Disposition 20b. Place of Disposition (Nama of Data 20c. Location - City or Town, Stata camatary, cramatory or othar placa) 1 ABurial 2 Cramation 3 Ramoval from Stata 6/11/99 4 ☐ Donation 5 ☐ Othar (Specify) NEW DALE CEMETERY BAKER, WV 21. Signatura of Funaral Sarvica Licansaa 22. Nama and Address of Facility BROWN FUNERAL HOME, 327 W. KING ST. PO BOX 821, MARTINSBURG, WV 25402

23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Batwaan Onset end Deeth **Physician** /Medical tmmediata Cause (Finat disaasa or condition resulting in deeth) Prevmania Examine Dua to (or as a consaquanca of): Ventilatory insufficience Examin law requires that the death certificate be executed physician end the buriel-trans Sequantially list conditions, if any, taading to immadiete causa. Entar Undarlying Causa (Disaasa or injury that Initieted events resulting in death) Last Dua to (or as a consequanca of): Neurologic decline Physician/Medical Dua to (or as a consaquanca of): Glioblastoma Multiforme signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hemorrhage into Glioblastoma þ 24b. Ware eutopsy findings available prior to should I 24a. Was an autopsy performed? Completed multiporme timor bed complation of cause of daath? is certificata has b I director, page 2 sl 1 Yas 2 No Division of Vital Physician: 25. Was casa refarrad to medical axaminar? Be 26. Placa of Daath (Check only ona) Hospitat: 1 Inpatiant 2 ER/Outpetient 3 DOA To Other: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 Yas 2 No this After this 27. Manner of Deeth 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred the Hospital or Attending Pi hin 24 hours after death. the Funeral Director: After the mpletaly filled in by the funera 28b. Tima of 28c. Injury at Work? Certification: 5 Pending invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not ba determined 3 ☐ Suicida 28f. Location (Straat and Number or Rural Routa Numbar, City or Town, State) 28a. Placa of Injury - At home, farm, streat, factory, offica building, atc. (Specify) 4 | Homicida Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the causa(s) and menner as stated.

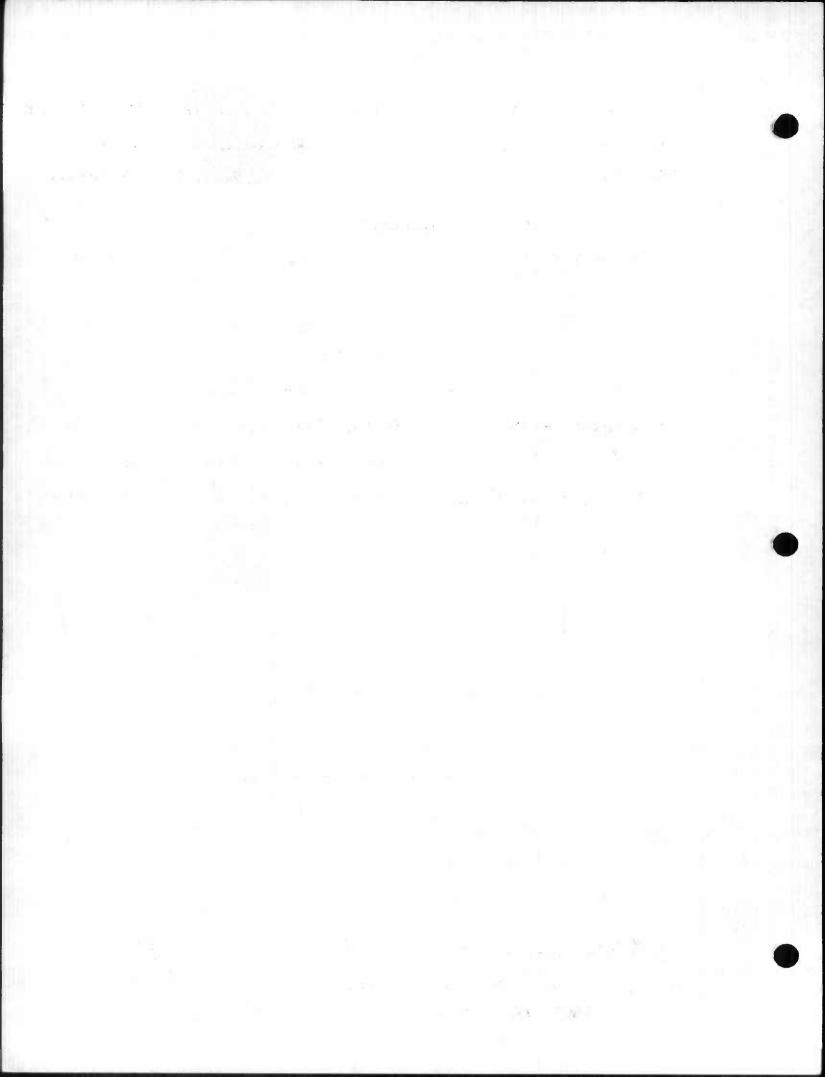
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the causa(s) and manner stated. edical 29a. Cartifier (Check only one) To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signad (Month, Dey, Year) Malance Medicine Housestaff RGS-000 30. Nama and address of parson who complated causa of daeth (Itam 23a) (Typa, Print) CAMILLE PEART METLANCE. JOHNS HOPKING HOSPITAL. 600 N. WOLFE STREET, BALTIMORE 31. Date filad (Month, Day, Year) 1999 32 Agnatura

State Registrar



State of Maryland / Department of Health and Mental Hygiene Q Q

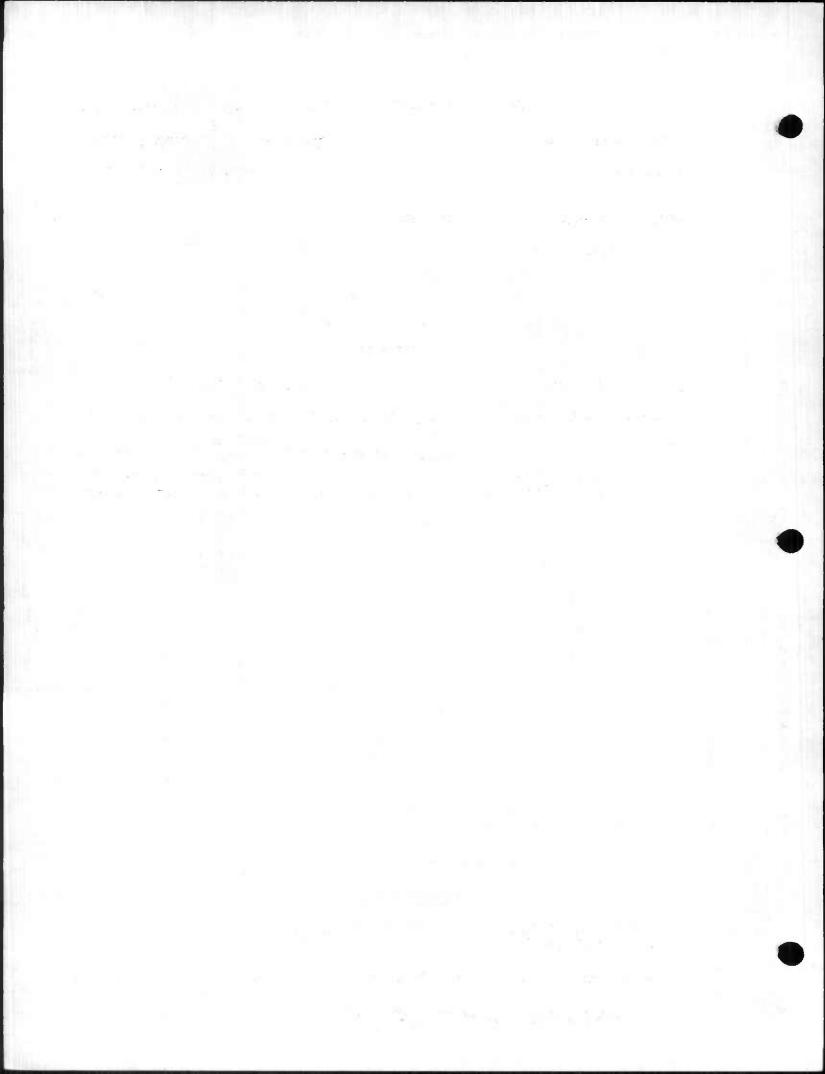
Examiner  Function  Function  Function  Figure 2  Clade Valley Nursing Home  Clade Valley Nursing Home  Social Security Number  15. Social Sec	_						Certifica	te of	Death	P	leg. No.	3 41	069
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Second Second Number   150 - 18-4   150 -				Glade Valley No	ursing Hom	e			Walkers	sville	Fred	lerick	
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29a. Certifier (Check only one) 20 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and placa, end due to the cause(s) and manner as stated.  29b. Signeture end titla of certifier 29c. License number 29d. Date signed (Month, Day, Year)  30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print)  Cerwit Albordary on the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and placa, end due to the cause(s) and manner as stated.  29c. License number 29d. Date signed (Month, Day, Year)  Cerwit Albordary on the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and placa, end due to the cause(s) and manner as stated.  29c. License number 29d. Date signed (Month, Day, Year)  Cerwit Albordary on the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and placa, end due to the cause(s) and manner as stated.  29c. License number 29d. Date signed (Month, Day, Year)  Cerwit Albordary on the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and placa, end due to the cause(s) and manner as stated.  29d. Date signed (Month, Day, Year)	8	- 43 (f)	lete									comple	ble prior to letion of cause
29a. Certifier (Check only one) 20 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and placa, end due to the cause(s) and manner as stated.  29b. Signeture end titla of certifier 29c. License number 29d. Date signed (Month, Day, Year)  30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print)  Cerwit Albordary on the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and placa, end due to the cause(s) and manner as stated.  29c. License number 29d. Date signed (Month, Day, Year)  Cerwit Albordary on the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and placa, end due to the cause(s) and manner as stated.  29c. License number 29d. Date signed (Month, Day, Year)  Cerwit Albordary on the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and placa, end due to the cause(s) and manner as stated.  29c. License number 29d. Date signed (Month, Day, Year)  Cerwit Albordary on the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and placa, end due to the cause(s) and manner as stated.  29d. Date signed (Month, Day, Year)	Be	has ge 2	E G								_		
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29a. Certifier (Check only one) 20 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and placa, end due to the cause(s) and manner as stated.  29b. Signeture end titla of certifier 29c. License number 29d. Date signed (Month, Day, Year)  30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print)  Cerwit Albordary on the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and placa, end due to the cause(s) and manner as stated.  29c. License number 29d. Date signed (Month, Day, Year)  Cerwit Albordary on the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and placa, end due to the cause(s) and manner as stated.  29c. License number 29d. Date signed (Month, Day, Year)  Cerwit Albordary on the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and placa, end due to the cause(s) and manner as stated.  29c. License number 29d. Date signed (Month, Day, Year)  Cerwit Albordary on the basis of examination end/or investigation, in my opinion, deeth occurred at the time, data and placa, end due to the cause(s) and manner as stated.  29d. Date signed (Month, Day, Year)	sion	ending seth. or: After the fune	cation	1 Neturel 5 Pending Invastigation		Year) 260.	Injury	Wo	ork?	28d. Dascribe III	ow injury occur	red	
30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print)  Gerws A Dol Gr. PN T. MN P.O. Bux 310 walkers all mn 21793	<u>S</u>	al or Att s after d il Direct ed in by	Certifi	determined 200. Flede of injury - At home, ferm, street, factory, office						28f. Location (St City or Town	treet and Numb n, State)	er or Rural Ro	oute Number,
30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print)  Gerws A Dol Gr. PN T. MN P.O. Bux 310 walkers all mn 21793		Hospit 24 hour Funera etely fills		(Check only 2 Medical Exam	Iner: On the basis of	examinetion en	a, death occurred nd/or investigetion	let the ti	ma, data and placa, opinion, deeth occurr	end due to the cred et the time, d	euse(s) and ma ate and pleca,	inner as state and due to the	d. e cause(s)
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		i		30 Name and address of asset	2 20	ath /lane and	(Time Date)	V 11	771		7//	0/1/	
				A 116	completed cause of de	P. (I M.	(Type, Print)	11/	Possello	MM 7	179	>	
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State of Maryland / Department of Health and Mental Hygiene

21070

						Cer	tificate of	Death		Reg. No.		41070		
	Physic /Medi		Decedant's Name (First, Middle	GRACE	ELIZ	ZABET	н ва	KER	2. Data of De Month	Day	Yaar 999	3. Tima of Death 11:53 AM		
3	Exami		4a. Facility Nama (If not institution,	giva street end number	er)			4b. City, Town, or		4c. County	of Death			
			3411 HARNEY					TANEYTOW			LL COL			
	Funeral			6. Sax 7 1 ☐ M 2 ☒ F	Age (In yrs. last	birthday) _ Yrs.	If Undar 1 Year Months Days	Hours Min.		th Y. Year)	9. Birthpla	aca (Stata or Foraign AND		
	Director		214-74-7808 Usual Rasidanca of Dacedent		30	110.			AUG. Z	1, 1908	MARYL	AND		
	Mand Mand		10a. Stata 10b. County		10c. City, Town or Location 10d. Inside City L									
	Many Many	to	MARYLAND CARRO	LL COUNTY	TANEY	TOWN						1 ☐ Yas 2 1 No		
	r 284	Director	10e. Street and Number				10f. Zip Coda			10g. Citizan of				
	h wit		3411 HARNEY	ROAD				21787		UNITED STATES				
	d within 72 hours after death with the Maryland jiena. Than "natural", or flams 23a or 28e-f show the Medical Examinet must be notified at	Funeral	11. Marital Statua	12. Wes Deceder		13. W	es Decedant of F	dispanic Origin? (S en, Mexicen, Puart	pecify Yas or No	- 14. Rac	ce - Amaricar			
2	or it		1 Navar Marriad 2 Marria				☐ Yes 20 No				y: WHIT			
3	ural'.	d by	3  Widowed 4 □ Divorced	Yaar or Dete										
71213-0020	"nat	lete	15. Decadant' (Specify only highas)	grada completed)	16	(Giva k	ant's Usual Occup ind of work done O NOT usa retire	during most of wor	rking	16b. Kind of B	usinass/Indu	istry		
7	within ena. than	Completed	Etamentery/Secondery (0-12)	Collega (1-4d	or 5+)		ÆMAKER	0)		OWN I	HOME			
0	高大な兵		17. Father's Name (First, Middle, L	ast)				18. Mothar's Nar	na (First, Middle	Maiden Sumar	na)			
Maryland	0 5 D W	To Be	IRA ALLISON ROI	OKEY				MARY A	NN HALT	ER				
aly	S E E	-	19a. fnformant's Neme/Ralationsh	lp (Type, Print)	1	9b. Mailing	Addrass (Street	and Number or Ru	ural Route Numb	er, City or Town	, Stata, Zip C	Code)		
			THOMAS W. BAKE	R / SON	3	409 F	HARNEY RO	DAD TA	NEYTOWN	, MARYL	AND	21787		
	permit. Peges 1 and Department of Healt Important: If Itam 2: any injury or other: once.		20a. Mathod of Disposition	2 DP 04	00.000	of Dispos	ltion (Nama of atory or other ple	ce)	JUNE 18	20c. Location	- City or Tow	n, State		
ĺ	Peg nent: H ury o		1. Burial 2 ☐ Crametion 4 ☐ Donation 5 ☐ Othar (Sp					CEMETERY	1999	TYRONE	, MARY	TLAND		
Dalimore,	Departr Departr Imports any Inf		21. Signatura of Fufieral Service L	icenses 6-0		22.	Name end Addra	ss of Fecility SI	KILES FU	NERAL H	OME			
3	82729		John /11-	Attile.	9	136	5 EAST B	ALTIMORE	STREET	TANET	YOWN,	MD. 2178		
	-		23a. Part1. Entar tha diseasa, or o	omplications that caus	sed the death. D	o not enta	tha mode of dyle	ng, euch as cardiad	or respiretory a	rrest,	1 1	Approximete Intarvat Between		
	Physician			, , , , , , , , , , , , , , , , , , , ,								Onset and Death		
	/Medical Examiner		Immediata Causa (Finel disaasa or condition	A	cute myc	ocard:	ial infa	rction			mi	inutes		
	LXUITITO		rasulting In daath)		Due to (or as						and and			
	ted nsit	nin		b			ry disea	se 						
,	certificate be asscuted anding physicien and use as the burial-transit	Examiner	Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Causa (Disaesa or Injury		Dua to (or as	a consequ	ence of):				i			
00/00	e be		thet initiated evants	C	Dua to (or as	8 00000000	ance of):				- !			
0	tificat g phy as th	n/Medical	rasulting In death) Last		Dua 10 (01 a3 1	a consequ	once ory.				t			
	th cer endir r use	No.	N N	d						***	<u> </u>			
0	The lew requires that the death ate has been signed by the atter page 2 should be datached for	Physician	Part ft. Other significant condition	s contributing to death	n but not rasulting	In the un	darlying cause giv	ven in Pert I.	23b. Did	tobacco use co	entribute to t	the cause of death?		
	d by t	Phy							10	Yes 2⊠ No	3 Probe	ably 4 Unknown		
2	the d	þ												
5	been s	Completed								en autopsy emed?	avail	e eutopsy findings lable prior to pletion of cause		
ב	has b	mpi									of de	eath?		
	cate								10	Yaa 2 No	10	Yas 20 No		
	ilclen: The cartificate rector, pag	Be	25. Was case refarred to medical examiner?	Hospital:			all post Oth	AAC:	ath (Check only o					
5	Physician: r this cartific and director,	. To	1 Yes 2 No 27. Mannar of Death	1 L Inpa	atient 2 ER/	Outpatient  Tima of	3LI DON	4 D Nuising F	Ioma 5 Resi	dance 8 Oth				
5	ding After fune	tion	1 ⊠Natural 5 ☐ Pending		Day Year)	Injury	28c. fnjur Wor M 1 🗆	rk? Yas 2 □ No	200. Dascribe	now injury occur	red			
DIVISION OF VICE RECOIDS,	or Attanding effer death. Director: Affer I in by the fune	fica	3 Sulcide 6 Could no	at be	Injury - At home.	ferm stre		140 2 1110	28f. Location (	Street and Numi	ber or Rural I	Route Number.		
Š	effer Direction of the control of th	Certification:	4 Homicida	building,	Injury - At home, atc. (Specify)		an incomy, omoo		City or To					
	To the Hospital or Attending Physician: The i within 24 hours effer death.  To the Funeral Director: Affer this cartificate he completely filled in by the funeral director, page	- 1	29a. Cartifiar	Physician: To the bes	st of my knowled	ga, daath	occurred at tha tir	ma, data and place	, and dua to the	causa(s) and m	anner as sta	ted.		
	n 24 l	edicai	(Check only 2 Medical E	xamfner: On the basis end manner	of axamination a	and/or Inva	stigation, in my o	pinion, death occu	rred at tha tima,	data and place,	and due to the	he causa(s)		
	withly To th	M	29b. Signetura and Illie of certifier	////			29c. Licans			29d. Dete signe	d (Month, Da	ay, Year)		
			( Clad	/alla	112		MDO1	5567E		6-1	6-99			
			30. Nama and address of parson w								<u>-</u>			
			Ronald Kra	olin, M.D.	423	Sout	n Washin	gton Stre	eet Ge	ttysbur	g, PA	17325		
	Sta		31. Data filed (Month, Day, Yaar)		strar's Signetura	/	,							
	Registr	ar	JUN 1 8	1999	Jenera	B	. Spar	Ks						
MUR	ILI 16 Day CM	5				-	-							



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month 27ay 1999ar Earl Eugene Bowser 12:41 P.M. 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Colton Villa Nursing Center Hagerstown Washington If Under 1 Year Hunder 24 Hrs. 8. Date of Birth Months Days Hours Min. April 1978, 1918 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign MCL. 1 M ° 2 □ F 220-30-9666 81 Yrs Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Washington Chewsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21016 Twin Springs Dr. 21721 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bieck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorcad 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Laborer Landscape 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Isaiah Bowser Etta Pearl Kendall 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn E. Flair (Niece) 118 Sundown Ct. Unit 1-A Hagerstown, Md. 21740 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Remove from State Smithsburg Crematory June 26,1999 Smithsburg. Md. 5 Other (Specify) Signature of Funeral Servica Lice 22. Name and Address of Fecility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediete Cause (Finel LUNG CARCINOMA non oatcell disease or condition resulting in death) Metastasis Moulu Due to (or as e consequence of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco usa contribute to the causa of death? 7 Yes 2 □ No 3 Probably 4 ☐ Unknown noul 24a. Was en eutopsy performed?

Physician /Medical Examiner

**buriel-transit** 

nding physician use es the bune

certificate has

To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I

Examiner

Physician/Medical

by

Completed

Be

Certification: To

Medicai

**Physician** 

/Medical

**Examiner** 

Director

by

Completed

Be

10a State

**Funeral** 

Director

the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hyglena. Important: If them 27 is marked other than "natural", or items 23s or 28s-4 show any injury or other traumatic event, if is Modicial Exprinse must be notified at

3altimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

24b. Were autopsy findings available prior to completion of cause of death?

20 NO

1 ☐ Yes 20 No

as case referred to medical				2	6. Place of Death (C	heck only one)	
Yes 2000	Hospital: 1 ☐ inpatient	2 ☐ ER/Outpatient	3□ DOA	Other:	A Nursing Home	5 Residence	6 ☐Other (Specify)

212N0 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manper of Death 28a. Date of injury (Month, Day Year) 28b. Time of 5 Pending investigation 1 Naturei

28c. Injury at Work?

28d. Describe how injury occurred

1 Yes 2 No 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and menner stated.

(Check only one) 29b. Signature and title of certifier

2 Accident

3 Sulcide

4 Homicide

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

6 Could not be determined

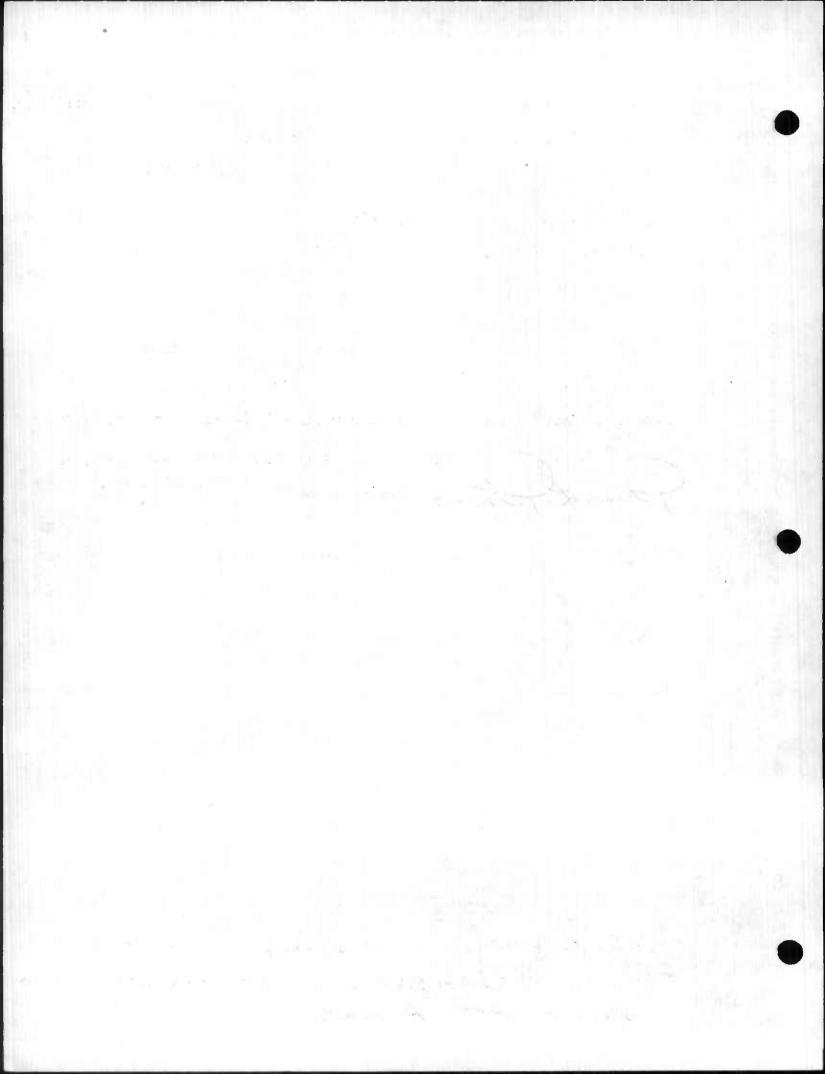
D28365

State Registrar

31. Date filed (Month, Day, Year) JUN 2 3 1999

MANZAR

HAFI 368 MILL STREET HAGERS TOWN MO21740 2 32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last)

2. Dete of Deeth Dey 1999 18, 10:08 P.M. LAVALETTE IMOGENE BUTLER JUNE 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth WILLIAMSPORT NURSING HOME WILLIAMSPORT WASHINGTON 7. Age (In yrs. lest birthdey) If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 9. Birthplace (Ste (Month, Day, Year) 1908 MARYLAND 5. Social Security Number 9. Birthpiace (Stete or Foreign **Funeral** 1□M XXF 216-38-1145 Director Usuel Residence of Decedent with the Marylend Show 10a Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show traumatic svent, the Medical Examiner man be notified all XXYes 2□ No Director MARYLAND WASHINGTON HAGERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 717 SUNSET AVENUE 21740 U.S.A. 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. should be filed within 72 hours after of Mentel Hygiene. marked other than "naturel", or lies 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: by 3 N Widowed 4 □ Divorced WHITE 16a. Decedent'a Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 YEARS PERSONAL RESIDENCE HOMEMAKER 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Peges 1 and 2 should be finent of Health and Mentel First: if item 27 is marked of EDWARD BENTON MCNAMEE GOLDIE FORREST SHOWE 19a. Informent'a Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health an Important: if item 27 is any injury or other trausonce. WILLIAM R. MCNAMEE/BROTHER 1408 SOUTH POTOMAC STREET, HAGERSTOWN, MD 21740 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) ST. MARKS CEMETERY 06/22/1999 LAPPANS, MARYLAND 21. Signeture of Funerel Service Licensee D. 84 Danlett, O. 22. Neme end Address of Fecility 7606 OLD NATIONAL PIKE STEVEN DANFELT, JR. BAST FUNERAL HOME BOONSBORO, MARYLAND 21713 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final · CONGESTIVE HEART FAILURE YEARS diseese or condition resulting in death) Examiner Examiner ISCHEMIC CARDIO MYOPATHY that the deeth certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieled events resulting in death) Lest pue Box 68760. physician CORONARY ARTERY Physician/Medicai Due to (or es e consequence of): the P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 XNo 3 Probably 4 Unknown been signed to should be deta MULTIPLE CEREBRAL INFARCTS Records, þ 24a. Wes en eutopsy performed? 24b. Were autopsy findings evalleble prior to Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yea 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1☐ Yes 2XNo 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) Medical Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, dete and piece, and due to the cause(s) end menner es stated.

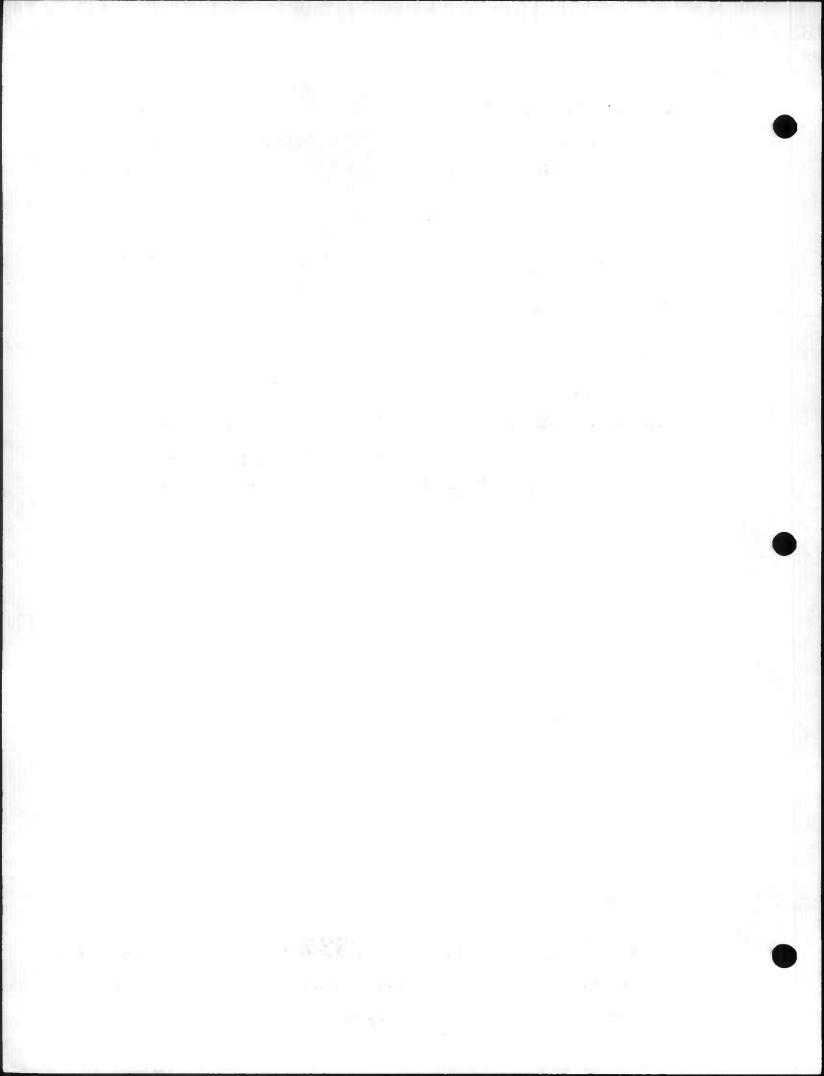
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) 29a, Certifier end menner steted. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) JUNE 20, 1999 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) DRIVE, BOONSBORD, MD 21713 IED E. HOWE 7542 OVERLOOK 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

JUN 2 1 1999

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6-13-99

after death. Page 6 may be retained by the hospital or attending physician.

y the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 6 may be retained by the hos TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISIÓN OF VITAL RECORDS, P.O. BOX 68760

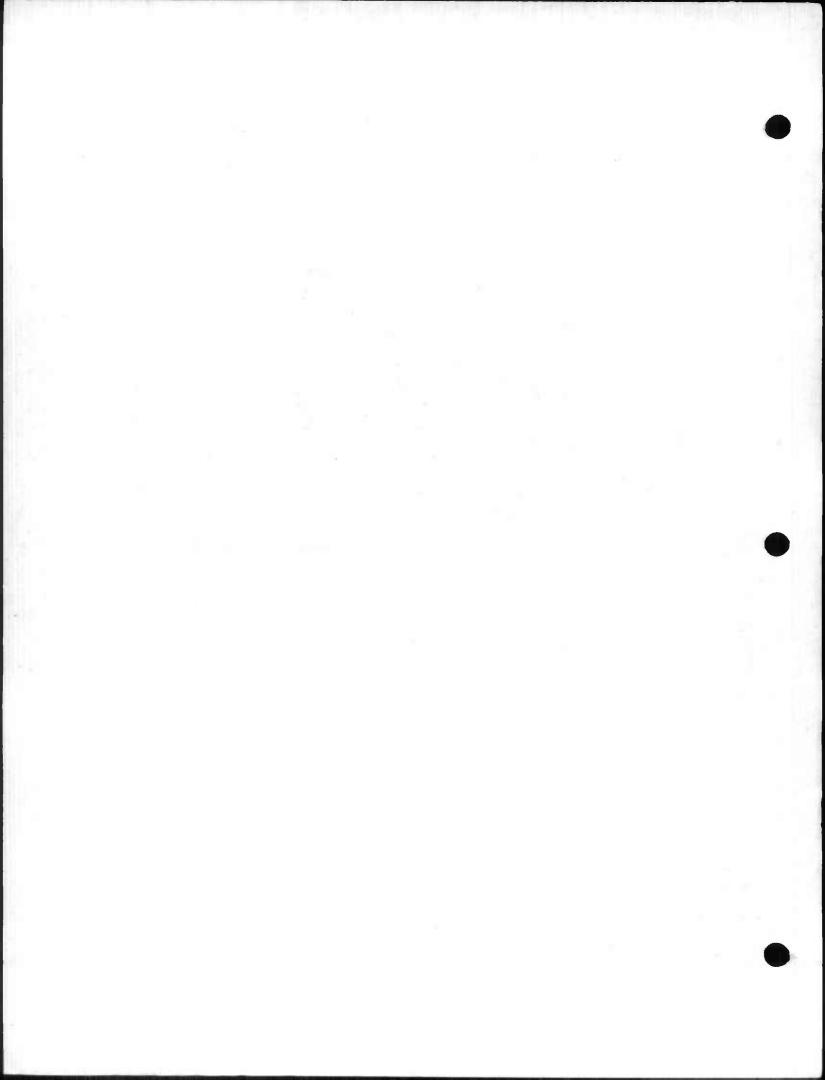
RICHARD

Bueyer,

	director.	
	STOR: After this certificate has been signed by the attending physician and completely filled in by the funeral directo	
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i	d in b	or ref
1	filled	HOU.
	pletely	after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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2	this (	William
2	After	death
1 1 1 1 1	JOR.	after

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFIC	ATE OF	DEATH	RE	G. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF D	EATH	W	3. TIME OF DEATH
	Richard	Thomas		BURGER		MONTH JU	ine, MY	99	5:35 AH
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In	yrs. last birthday)   II	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BI	RTH	8. BIRTI	HPLACE (State or Foreign
	219-14-7577 1 № M 2	□ F 7	3 YRS.	ONTHS DAYS	HOURS MIN.	Oct.18	-	Mar	yland
	9e. FACILITY NAME (If not institution, give street end nun	nber)	9	b. CITY, TOWN C	R LOCATION OF DE			DUNTY OF E	
DIRECTOR	Homewood Retirement Ce	nter		Willi	amsport			WASHI	NGTON
입 입	too. STATE 10b. COUNTY		10c. CITY, 1	OWN OR LOCAT	ION				10d. INSIDE CITY
<u>۳</u>	Maryland Washingto	n	Wi	lliamsp	ort				LIMITS? t 🛱 YES 2 □ NO
	10e. STREET AND NUMBER				ZIP CODE		10g, C	TIZEN OF	WHAT COUNTRY?
FUNERAL	1 North Artizan St.				21795			USA	
5	FOROS	ECEDENT EVER IN I		ta. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Sp	ecify Yee or No-	- t4. RAC	E — American Indian,
BY		, GIVE WAR OR DAT		1 TYES			, wear	Spec	
	15. DECEDENT'S EDUCATION	-	16a. DECEOENT'S US	UAL OCCUPATION	N	16b. KIND	OF BUSINESS/	INDUSTRY	MILLIE
	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (	1-4 or 5 +)	(Give kind of work life. Do NOT use r	k done during mo etired.)	st of working				
COMPLETED	10 0		Cable Sp	olicer		Te	elephone	e	
ខ្ល	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAI				
BE	William Augu	stus	Burge		Hilda	Luci		Rand	all
၉	190. INFORMANT'S NAME (Type/Print)  Nancy E. Burger				St. Wil				5
	20e, METHOD OF DISPOSITION	201-6	PLACEANDDATEOF	-		DATE	20c. LOCATION		
	1 D Burlel 2 Cremetion 3 Removal from S	tate cemei	tery, cremetory or other	r place)					t, MD 21795
	21. SIGNATURE OF FONERAL SERVICE LICENSEE	1 Gre	eenlawn Mem		D ADDRESS OF FAC	and of of	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	оро.	1, 110 21755
	·//logor/M/XX	ne-	-	OSBOR P.O.B	NE FUNERA ox # 348	AL HOME	msport	. MD	21795
	23. PART I. Enter the diseasea, or complication about, or heart failura. List only of	one that caused	the death. Do not						Approximate
- 1	IMMEDIATE CAUSE (Final	One cause on aad	ch line.	1.	/ /	~ /			Onset and Death
- 1	disease or condition resulting in death)	MOX	roplace	(0)	le/al	SCIN	1050	- 1	Mary
	, , , , , , , , , , , , , , , , , , ,	OUE TO (OR AS A	CONSEQUENCE OF):					1	
Z	Sequentially list conditions, b.								
Ĕ	If any, leading to immediate cause, Enter UNDERLYING	DUE TO (OR AS A C	CONSEQUENCE OF):						
CERTIFICATION	CAUSE (Disease or injury C.	DUE TO (OR AS A (	CONSEQUENCE OF):						
	that initiated eventa reaulting in death) LAST	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,						
핑	d								
AL	PART ii. Othar algnificant conditiona contribu	iting to death bu	t not reaulting in	the underlying	cause given in	Part i. 24e.	WAS AN AUTOP! PERFORMED?	3Y 24	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
DICAL						10	YES 2 NO		COMPLETION OF CAUSE OF DEATH?
W									1 TES 2 NO
SICIAN: ME	DID TOBACCO USE CONTRIBUTE 1	O CAUSE OF	DEATH YES	□ NO □	UNCERTAIN	N 🗆			
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPIT		6. PLACE OF DEATH	(Check only one)					
YSI	1 YES 2 NO t Inpat	lent 2 - ER/Outpe			e 5 🗆 Reeldence	6 Other (Spe	ecify)		
PHY		DATE OF INJURY (Month, Day, Year)	26b. TIME (		URY AT RK?	28d. DESCRIB	E HOW INJURY	DCCURED	
BY	2 Accident Investigation				ES 2 NO				
	3 Suicide 6 Could not be 4 Homicide datermined	PLACE OF INJURY - building, etc. (Specif	— At home, ferm, atre	eet, fectory, affic	•	281. LOCATION	N (Street and Num wn, State)	ber or Rural	Route Number,
<u> </u>	290. CERTIFIER								
릴	(Check only CERTIFYING PHYSICIAN: To the								
COMPLET	2 MEDICAL EXAMINER: On the b	eele of examination	end/or investigation,	In my opinion, d	eath occured at the	time, date end	plece, end due to	) the Ceuse(	e) end menner es stated.
BE	296. SIGHATURE AND TITLE OF CENTRAL TO				29c LICENSE NUN	MBER			D (Month, Day, Year)
2	Mille				1)66	sec	>	Jelu	14 1988
	30. NAME CAND ADDRESS OF PERSON WHO COMPLETED ALLEN W DITTO MD	747 NAG	THE EN F	ture L	AgersTi	DWN	Mn 21	74:	2
	31. DATE FILED (Month, Day, Year) 32. R	EGISTRAR'S SIGNA	TURE /	1	1				
	.WN 1 5 1999	Depende	J.	Spork	2				



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attenting physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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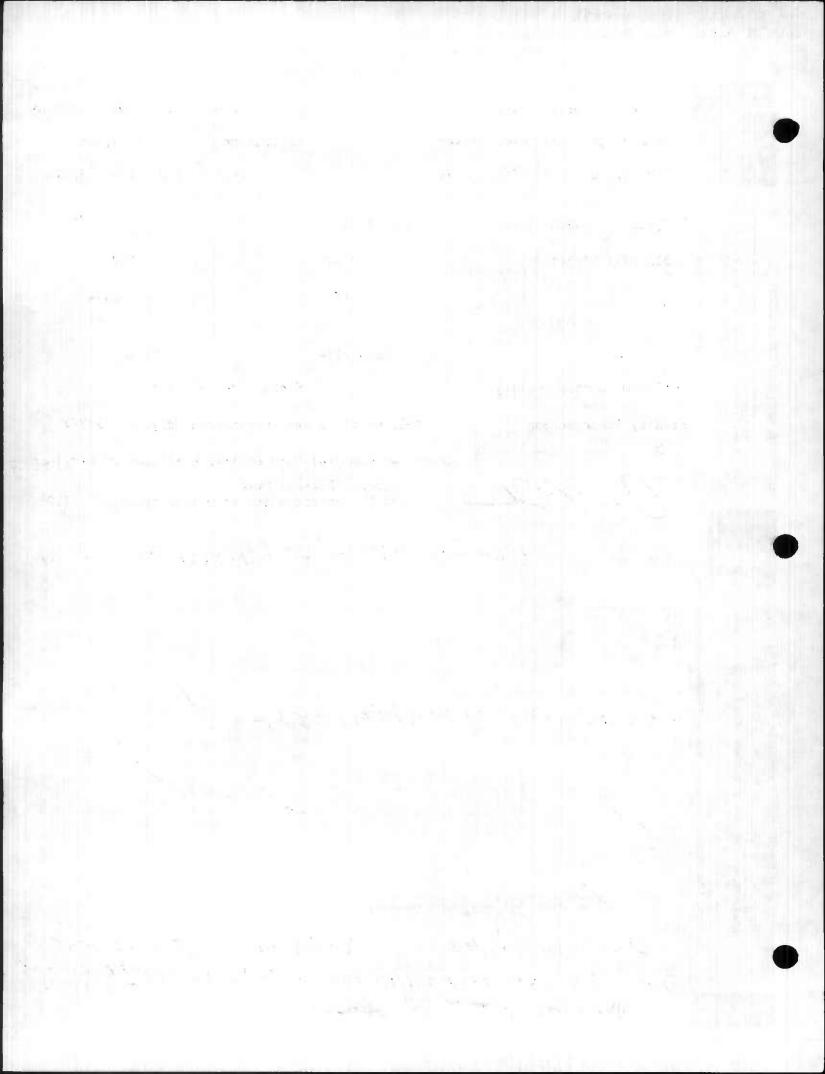
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

## STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

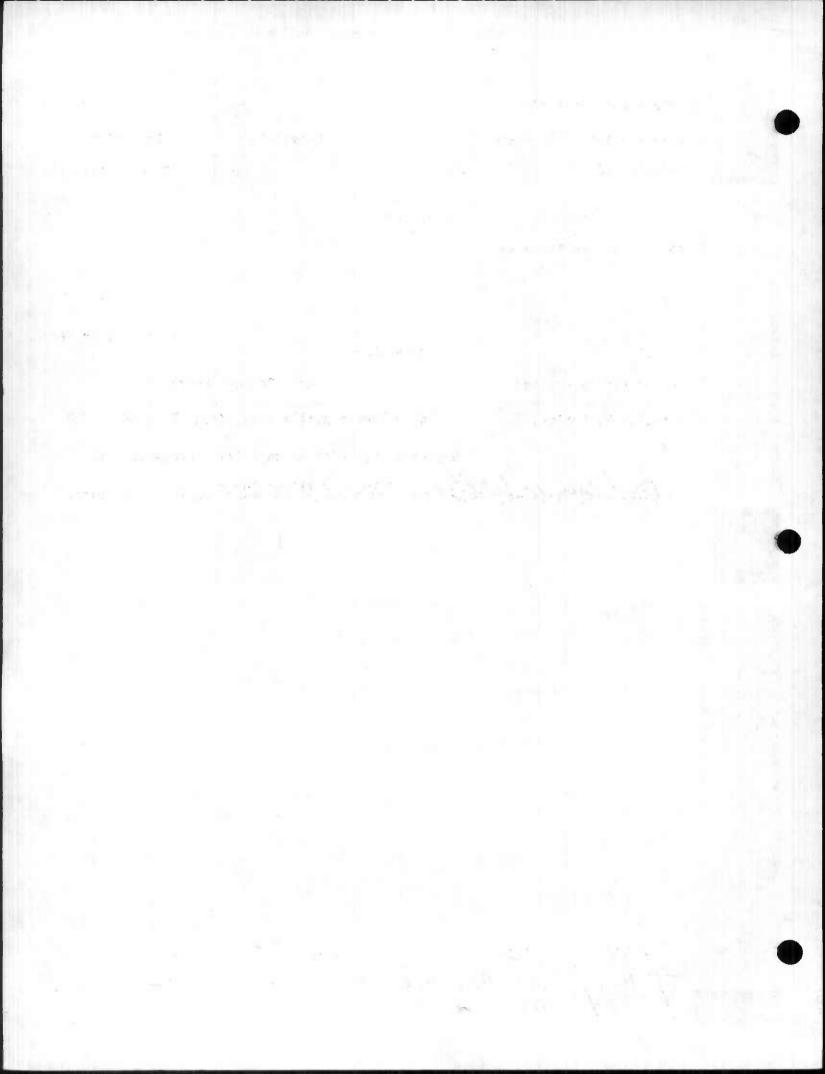
	1. DECEDENT'S NAME (First,	Middle, Last)	·							2. DATE OF DEATH			3. TIME OF DEATH
	Claude Bank	s BYER	S							June 12		YEAR	3:55 <sup>P</sup> M
	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In yrs. la	st birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7 DATE OF BIRTH			LACE (State or Foreign
	294-09-0725		1 🖾 M 2 🗌 F	82	YR\$.	MONTHS	DAYS	HOURS	MIN.	Dec. 16,1	916	Country)	Virginia
~	9n. FACILITY NAME (If not in			1					ON OF DE	ATH	9c. COU	NTY OF DEA	
DIRECTOR	Washington		Hospita	11		1	lage	rsto	vn			Wash	nington
E C	10e. STATE	10b. COUNTY			10c. CIT	Y, TOWN	OR LOCA	TION					IOd. INSIDE CITY
	Maryland	Washi	ngton				Hag	erst	own			1	LIMITS? YES 2 NO
FUNERAL	531 West	Howard	Street				10	f. ZIP COD	E 21740		10g. CIT	USA	IAT COUNTRY?
BY FUN	11. MARITAL STATUS  1 Never Married 2 3 Never Married 2 Divo		FORCES? 1	IT EVER IN U.S. AI YES 2  WAR OR DATES	NO		If yes, sp	CENDENT Concepts of the Concep	n, Maxican	C ORIGIN? (Specify Yea , Puerto Ricen, etc.)	or No-	14. RACE - Black, Specify	- American Indian, White, atc. White
	15. DEC	EDENT'S EDUC	W.W.	16a, Di	ECEDENT'S	USUAL O	CCUPATI	ON		16b, KIND OF BUS	RINESS /IM	WIS TRY	WIIIEC
COMPLETED	(Specify only Elementary/Secondary (0 12	y highest grade (	Completed)  College (1-4 or 5	+) (C	ive kind of b. Do NOT u ruck	work done se retired.)	during me	ost of worki	ng	rail		,00	
Ö	17. FATHER'S NAME (First, M.							18. MOT	HER'S NAM	ME (First, Middle, Maiden	Sumame)		
BE	Joseph By								31anc				
2	Lynn Byers	- son		19							liams	port,	Md. 21795
	20a. METHOD OF DISPOSITE tX Burlel 2 Cremetic 4 Donetion 5 Other	n 3 🗆 Remo (Specify)		20b. PLACE cemetery. cra Gre	ematory or o	ther place!			Park	6-15-99 T		amspo	
	21. SIGNATURE OF FUNERAL	SERVICE LICI	M/		1				ss of fac	TILIVIA.			AL HOME Md. 21740
	23. PART I. Enter the d	iseesea, or c	omplications the	ot caused the de	eath. Do	not enter	the mo	de of dy	ing, such	sa cardiac or respi	ratory ar	reat.	Approximeta
}	ahock, or he IMMEDIATE CAUSE (Fire	aert fallura. L	let only one car	use on each line	B.							,	Interval Between Onset and Death
	disease or condition resulting in death)	<b>→</b>	Нурег	tensive	Caro	dio V	Jasc	ular	Dise	ase			years
I				(OR AS A CONSE									
NO O	Sequentially list conditi		DUE TO	(OR AS A CONSE	OHENCE O	E).							
CERTIFICATION	If any, leading to imme- cause. Enter UNDERLY	NG	302.10	(OII AO A OOIIGE	OULINGE O								
Ē	CAUSE (Disease or Inju	·	DUE TO	(OR AS A CONSE	OUENCE O	F):							
ER	resulting in death) LAS										_		
	PART II. Other algnifice	nt conditions	contributing to	death but not	resulting	in the ur	nderlyin	g cause	given in F	Part I. 24s. WAS AN		24b. V	VERE AUTOPSY FINDINGS
MEDICAL										PERFOR			WAILABLE PRIOR TO COMPLETION OF CAUSE
											C NO		F DEATH?
	DID TOBACC	O USE C	CONTRIBUT	E TO CAU	ISE OI	F DEA	TH '	YES [	] NO	X			
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:			0711-		LACE OF D	EATH (Chec	ck only one)			
YSI	1X YES 2 NO		1 Inpetient 2	ER/Outpetlent	X DOA	OTHEI		10 5 🗆 Ra	aldence 8	3 Other (Specify)			
ву рн		Pending Investigation	26a. DATE OF (Month, E		26b. TIM	IE OF JURY M	WC	URY AT ORK? YES 2	NO	28d. DESCRIBE HOW I	NJURY OC	CURED	
	3 Suicide 6	Could not be determined	28a, PLACE C building,	F INJURY — At he etc. (Specify)	ome, farm,	street, fac	lory, offic	a		281. LOCATION (Street a City or Town, State)	and Number	or Rural Roo	ute Number,
٦	29a. CERTIFIER (Check only	IFYING PHYSIC	IAN: To the best of	my knowledge, de	eath occurr	ed at the t	lime data	and place	and due t	to the cause(a) and man	ner en ete	ad .	
COMPLETE										ime, data and place, an			and manner as stated.
BE C	296. SIGNATURE AND TITLE	OF CERTIFIER	011	,				29c. LICI	ENSE NUMI	BER	29d. DAT	E SIGNED (A	Vonth, Day, Year)
2	30. NAME AND ADDRESS OF	L W,	COMP. TYPE	une				DO	1062		Ju	ne 14	, 1999
	Edward W. D				w 27) (Type		gto	n St.	На	gerstown,	MD	2174	.0
	31. DATE FILED (Month, Day, JUN 1	5 1999	32. PSGISTR	PIC AUGNATURE		Space		_					
			_										

Registrar



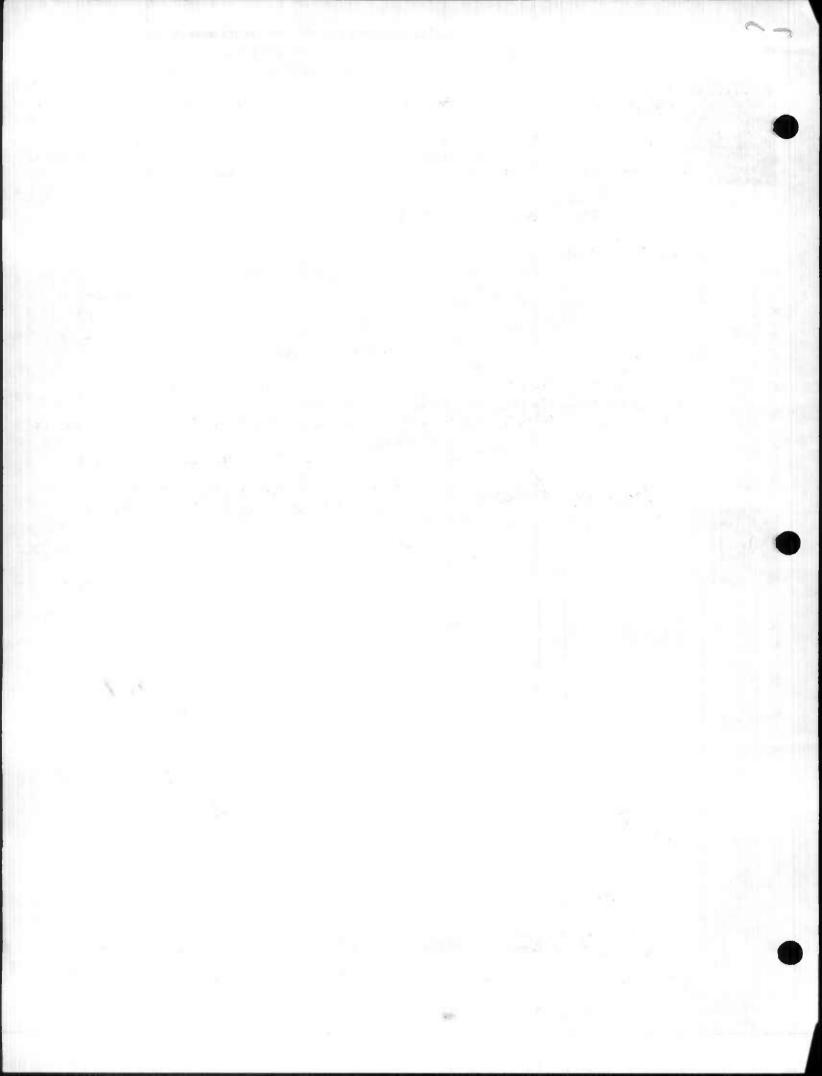
State of Maryland / Department of Health and Mental Hygiene 99 21076

					Cei	tificate of	Death			Reg. No.		21010
Dhyei	oion	1. Decedant's Neme (First, Middle, La	rst)						2. Data of D Month	eath	Veer	3. Tima of Death
Physic /Med		Acheir Eugenia Bu	utler						June	13 <sup>Day</sup>	1999	7:40 am
Exam	iner	4a. Facility Nema (If not institution, give		er)					cation of Dea	th 4c. Cour	nty of Death	
		4918 Burkittsvill 5. Social Security Number 6.5		A == (la ves la v	h fadh ata a b	If Under 1 Yaar	Knoxv				ederi	
Funera Directo			1 □ M 2 □ XF	Aga (In yrs. lesi 101	Yrs.	Months Days		Min	8. Data of Bi (Month, D Aug 15	1897	Burki	placa (Steta or Foreign intry) ttsville M
yland		10a. State 10b. County		10c. City, T	own or Lo	cation						10d. Inside City Limits
he Mer 28a-f st	Director	MD Freder	rick	Kno	xvill							1 Yas 2 No
23a or 2		10e. Street end Number 4918 Burkittsvill	e Road			10f. Zip Coda 217	58			10g. Citizan o USA		intry?
15-0020 72 hours after death with the Meryland "natural", or flerns 23a or 28a-f show edical Examinar mant be mutified at	by Funeral	11. Marital Status  1 Nevar Merried 2 Married  3 X Widowed 4 Divorced	12. Wes Dacada Armed Force 1  Yas 2 If Yas, Giva Yeer or Data:	s? ŽNo	1	Nas Decedant of f Yas, specify Cub I ☐ Yas 2 🕱 No	oen, Mexicar	n, Puarto	ncify Yas or N Rican, etc.)		ace - Amari leck, Whita cify: B	
72 hc	eted	15. Decedent's Ed (Specify only highast gra	ducation ada com <i>platad)</i>	1	6a. Deced (Giva	lant's Usual Occu kind of work done OO NOT usa ratire	pation during mos	it of worki	ng	16b. Kind of		
21215-0 d within 72 ho piene. r than "natur the Medical	Completed	Elamentary/Secondary (0-12)	Collaga (1-4c		Homen		9d)			Butler	-Holl	and Farm
yland 212  vuld be filed with  Mental Hygiene.  arked other than  atic event, the M	To Be C	17. Fethar's Nama (First, Middla, Last, Luther Dorsey Hol							(First, Middle ecca B	n, Maidan Suma	ıme)	
Mar d 2 sh d 2 sh th end 7 is m traum		19a. Informant's Name/Ralationship (Randolph W. Butle				g Addrass <i>(Str</i> aa Burkitt:						p Coda) 21758
Baltimore, permit. Pages 1 and Department of Healt important: If Item 2 any Injury or other once.		20e. Mathod of Disposition  1 ☑ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		te cem	atary, cran	sition (Name of natory or other pla n Memoria		dens	Date 6/15	20c. Location Freder		
Departit. Departmitimports any Inju		21. Signeture of Funeral Service Licer	13 m W	illia		Name and Addr John T 00 Peter			uneral			
Certificate be executed ding physician and case as the buriel-transit	Examiner	23a. Pert1. Enter the disaasa, or com shock, or heert feilura. List only Immediata Cause (Final disaesa or condition rasulting in death)  Sequantially list conditions, if eny, laading to immediata causa. Enter Undarlying Causa (Disaase or Injury	a	Due to (or es	M O ()	uance of):					1	Initarval Batween Onset end Deeth
	n/Medical	thet initiated events rasulting in deeth) Last	d	Dua to (or es	e consaqu	uance of):						
. 0 00	Physician	Part II. Other significant conditions o	ontributing to death	but not rasultin	g in the ur	idarlying cause gi	ivan in Part t	l.	23b. Did	tobacco use c	ontribute 1	to the cause of death?
es that the death igned by the etter be detached for a	by Phy	_1							1 🗆	Yee 20 No	3 Pro	obably 4 Unknow
aw requir	Completed b									s an autopsy ormed?	av cc	/are autopsy findings vailable prior fo empletion of cause daath?
ysicien: The list certificate hadirector, pege	Con								1 🗆	Yas 2 No	11	□Yas 2□No
icien: The	Be	25. Was casa referred to medical axaminar?	44					of Daeth	(Check only	one)		
_ S S	tlon: To	1 Yas 2 No  27. Mannar of Death 1 Naturat 5 Panding 2 Accident Investigation	Hospitat: 1 ☐ Inpa 28a. Deta of In (Month, E	njury 28	Outpatiens  b. Tima of Injury	28c. Inju		2	-	how injury occu		(ty)
or Attending Physical College of the	Certification:	2 ☐ Accident Investigation 3 ☐ Sulcida 6 ☐ Could not be 4 ☐ Homicida detarmined	e 28a. Place of t	tnjury - At home atc. (Specify)	, farm, stre	eat, factory, office	100 2			Straet and Num wn, Stata)	nbar or Flur	al Routa Number,
To the Hospital or Attending Ph Within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	edical C	29a. Cartiflar (Check only one)  1 Certifying Ph 2 Medicat Exam	yelcian: To the bes ninar: On tha basis end mennar	of examination	ige, daath and/or inv	occurred at tha ti estigation, in my	ma, date an opinion, daa	d place, a th occurre	nd dua to the	ceuse(s) and n data and place	nanner es a i, and dua t	steted. o the causa(s)
To the within To the	Me	29b. Signetura and titla of cartifiar				29c. Licens	sa number			29d. Dete sign	ed (Month,	Day, Year)
		Man -	mD			)	355	23		6/1	14/9	9
		30. Name end addrass of person who	completed causa of	daam (Itam 23	e) (Type, F	Print) RC(()	15WII	(k)	nd	21714	5	
Sta Regist	ate rar	31. Data filed (Month Pay, Fear) 8 1	999 <sup>32. Redis</sup>	strar's Signature	. 1	1. 100	atta.	1				mattern would manuscrape and



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Decedant's Neme (First, Middla, La		- I I I I I I I I I I I I I I I I I I I		cate of	Death	2. Data of De	Reg. No.	9 2	3. Tima of Death
Physic /Medi		HARRIETT	GIBSO		BELL				10, Day 199	_	9:00 AM
Exami Funeral	ner	4a. Facility Nama (If not institution, given 1813 CHATFIE  5. Social Sacurity Number 6. S	LD TER	RACE		indar 1 Yaar	SEVERAN  If Under 24 Hrs. Hours Min.				IDEL a (Stata or Foreign
Director		212-24-7162  Usual Rasidence of Decedent	□ M 2□X	76	Yrs.	ano Doyo	TOUIS WIII.	FEB.	14,192	3 MD	
anyland show	2	10a. Stata 10b. County  MD MONTG	OMEDV	10c. City	, Town or Location						Insida City Limits
the Marylar 28a-f show	Director	MD. MONTGO	JMERI		DICKER	SON f. Zip Coda			10g. Citizan of N	What Country	1 XYas 2 No
th with 23a or	al Di	6041 DICKERS	ON RD.							S.A.	
items items	by Funeral	11. Maritel Status  1 ☐ Nevar Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorcad	12. Was Decedan Armed Forcas 1 ☐ Yas 2 ☑ If Yas, Giva Yaar or Datas	? No		Decedant of H specify Cuba es 200 No	ispanic Origin? (Sp in, Maxican, Puarto Specify:	ecify Yas or No Rican, atc.)	- 14. Rad Blad	e - American ck, Whita, atc	
15-002	Completed	15. Decedant's Ed (Specify only highast gre	ducation da complated)		16a. Decedant's (Giva kind	Usual Occupa	ation during most of work	ing	16b. Kind of B	usiness/Indus	lry
d withir plene.	ошо	Elamantary/Secondary (0-12) 10 TH	Collaga (1-4or	5+)	CAFT		WORKER		SC	HOOL	SYS.
Maryland 21215-0020 d 2 should be filed within 72 hours af the end Mental Hyglene. T is marked other than "natural", or traumatic event, in Medical Example.	To Be C	17. Fethar's Nama (First, Middla, Last) WILLIAM	GIBSON				18. Mothar's Nam			na)	
		19a. Informant's Name/Ralationship ( SONYA LEE (	Type, Print) GRANDAU	CHMPT			and Number or Run				
Ore, es 1 an of Heat f item 2		SONYA LEE  20a. Mathod of Disposition  1  Spurial 2 Cramation 3  4 Donation 5 Other (Specif	Removel from State	20b. Pl	aca of Disposition matery, cramatory	(Nama of or other place	H. CEM	Data	20c. Location -		, Stata
Baltim permit. Peg Depertment important: i any injury o		21. Signature of Funaral Servica Licar	11.00.		22. Nan	na and Addres	ss of Fecility	FIINED	AT HOM:	P.	
Physician /Medicai Examiner		23a. Part1. Enter the disaase, or comshock, or hear failura. List only Immadiata Causa (Final disaasa or condition resulting In death)		urg	Can	CSL		or raspiratory a	rrest,		proximata terval Batween nsat and Death  rwelks  y 44  / ~ A
P #	iner	_	. ,		as a consequence						429
58760, cate be executed physician and the buriel-transit	Examiner	Sequentially list conditions, if any, laeding to immediata cause. Enter Underlying Causa (Disaasa or injury	-	1	as a consequence	of):					1 mgh
W = 0.8	n/Medical	Causa (Disaasa or injury that initiated evants resulting In daath) Last	d	-	es a consequance	of):					
). Box death cert he ettendin	Physician/M	Part II. Other significant conditions of	ontributing to death	but not rasul	Iting In tha undarly	ing causa give	an in Part I.	23b. Dld 1	tobacco use co	ntribute to th	e cause of death?
ords, P.O. Box requires that the death cert een signed by the ettendin hould be deteched for use	by Phy							10	Yes 2□ No	3 Probeb	ly 4□ Unknown
S S S S S S S S S S S S S S S S S S S	Completed								an aut <i>o</i> psy med?	aveile	autopsy findings ble prior to lation of causa ath?
- F # 8								10	Yas 20 No	1 □ Y	as 30 No
of Vital I Physicien: The this certificate ral director, pag	o Be	25. Was casa rafarred to medical axaminar?	Hospital:		700	Othe	26. Placa of Deat	. /			
On of of ding Physic After this of funeral dir	on: To	27. Mannar of Death  1. Naturel 5 □ Panding	28a. Data of Inj (Month, D	ury	ER/Outpatient 3E 28b. Tima of Injury	DOA 28c. Injury	4 Nursing Ho		dance 6 □Oth		
Division  To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	2 Accidant Invastigation 3 Suicide 6 Could not be 4 Homloida datarmined	28a. Placa of in	ijury - At hor tc. (Specify)	ma, farm, straat, fa	-	Yas 200No	28f. Location (S City or Tox	Street and Numb vn, Stata)	er or Rural R	oute Number,
e Hospita 124 hours e Funeral	Medical C	29a. Cartifiar (Check only one)  Cartifying Ph. 2 Medical Example (Check only one)	yalclan: To the bast liner: On the basis of and manners	of axamination	rladga, daath occu on and/or Invastiga	rrad at tha tim ation, in my op	na, data and placa, pinion, daath occur	and dua to tha red at tha tima,	causa(s) and ma data and place,	nnar as state and dua to the	d. a causa(s)
To the withir To the comp		29b. Signature and titla of cartifiar	Her	M	N	29c. Licansa			29d. Data signe	1	
		30. Nama and addrass of parson who c. T. Falkanaa	complated causa of	daath (Itam:	23a) (Type, Print)	or,	PASAN	lens,	plat	2112	22
Sta		31. Data filed (Month, Day, Yaar)	32. Regist	Ar's Signati	119 4	1					



mp-12821\_OAK HILL AVE. HAGERSTOWN, MO

State

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

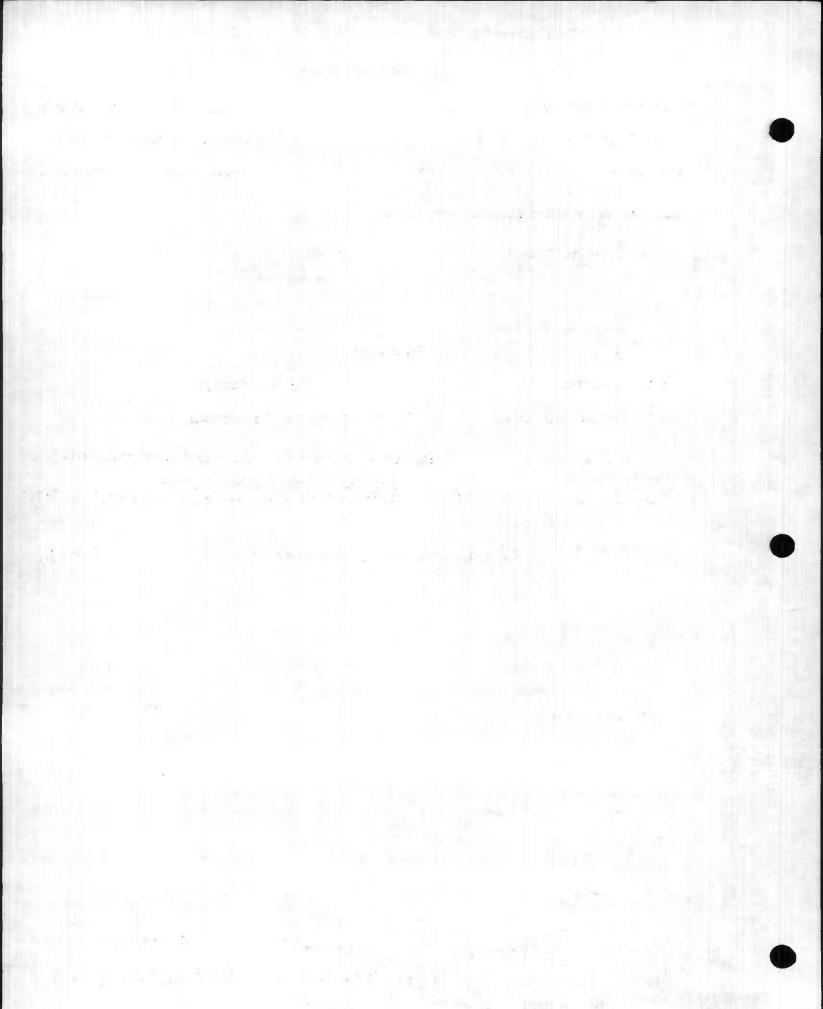
32. Redistrer's Signature

WAHTERD

H304L

31. Date filed (Month, Day, Year) JUN 1 6 1999

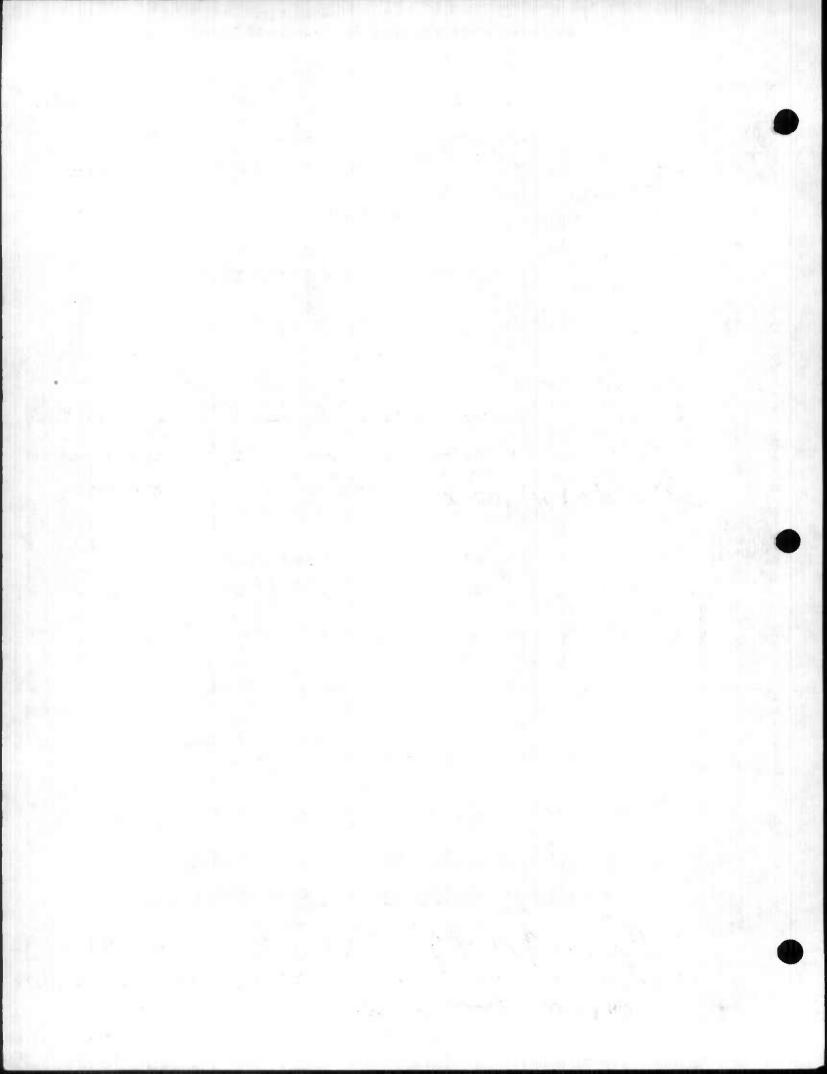
Marie



State of Maryland / Department of Health and Mental Hygiene 99 21079

						Ce	rtificate	of	Death		Re	eg. No.	6	1019
	Physic /Medi		1. Decedent's Nama (First, Middle, I Barbara Lou	ise Ca	•	1					of Deat	Day199	gaar	3. Time of Death 11:40 P. N
	Exami		4a. Facility Name (If not institution, g Colton Villa	ive street and no Nursing	um <i>ber)</i> g Center					wn, or Location o	f Death	4c. County Washir		
	Funeral Director		5. Social Sacurity Number 161-30-6305  Usual Rasidence of Decedent	Sax 1□M ¾□F	7. Age (In yrs. 74	last birthday, Yrs.	If Under 1 \ Months D	aar ays	if Undar Hours		of Birth oth Day. 20,	1925	9. Birthple Countr De La	aca (State or Foreign ry) Ware
	Maryland H show	tor	10a. Stata 10b. County Maryland Washing	gton	10c. Ci	ty, Town or Lo	ocation Igersto	wn					100	d. Inside City Limits 12 Yas 2 □ No
	with the	I Director	10e. Street and Number 528 W. Franklin S	Street			10f. Zip Co		740		10	0g. Citizen of V		y?
020	a within 72 hours after death with the Maryland liene. Than "natural" or items 23a or 28s-f show the Medical Examine must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 Marriad  3 □ Widowed 4 □ Divorced	12. Was Dec Armed F	2X No ive		Was Deceden	of I	tispanic Orl	gin? (Specify Yas n, Puarto Rican, a	s or No-	14. Rac	e - Amarica ck, Whita, at	
Maryland 21215-0020	S . 9	Completed	15. Decedent's I (Specify only highast g Elementary/Secondary (0-12)	rade completed)	) (1-4or 5+)	(Give	dent's Usual O kind of work of DO NOT use n	lone etire	pation during most d)	t of working		16b. Kind of Bi		ıstry
land;	tal Hyg d other	To Be C	17. Father's Name (First, Middle, Las Joseph Alvin Lan	•					18. Mothe	or's Name (First, I		Maiden Suman	10)	0
, Mary	nd 2 salth ar alth ar 27 is r trau		19a. Informant's Name/Relationship Jean C. Dunn		ghter	19b. Maili 528 W	ng Address (S I. Fran	reer k1:	and Numbe	er or Rumal Rouma ceet Ha	Number,	City or Town, town, I	state, zip d Maryla	and 21740
Baltimore,			20a. Mathod of Disposition  1 TBurial 2 Cremation 3  4 Donation 5 Other (Spec		State	cemetery, cre	osition (Nama omatory or other en Ceme	rpla		Date 6/15/		20c. Location - Hagers		m, State Maryland
Balt	permit. Pages Department of Important: If it any injury or once.		21 Shaatura of Funaral Service Lice 23a. Part1. Enter the disaase, or conshock, or heart failura. List only	mi	MOS caused the dear	G	2. Name and A erald N uneral ter tha mode of		Minni	ch 305	N. gerst	Potoma	c Str	eet nd 21740
	Physician /Medicai Examiner	ər	shock, or heart failura. List online immediate Cause (Final disease or condition resulting in death)	a	ZESPIR Due to (	A70 R	4 7/-	112	LORE				1	4 hours.
68760,	certificate be executed ding physician and se as the burial-transit	cai Examlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Infilated events	b	Due to (d	or as a conse	quence of):	7,	a wil	ti Meto	s tal	nc Pis	east	2 MONTH
×	din din	n/Medicai	resulting in death) Last	d	Due to (c	r as a consec	K (Juence of):						1	a
, P.O. Bo	es that the death igned by the etten be detached for u	y Physiclan	Part II. Other significant conditiona	contributing to d	leath but not res	ulting in the u	nderlying caus	a giv	ven in Part I.	. 231		bacco uae co	ntribute to t	the cause of death?
Records,	e law requires has been sign ge 2 should be	Completed by								248	. Was ar	n autopsy ned?	avail	e autopsy findings lable prior to pletion of cause eath?
Vital R	The ate h	Be Com	25. Was case referred to medical						00 81	15 -11 (0)	1 □ Ye	-	10	Yas 2 No
>	Physician: r this certific rral director,	0	examiner? 1 ☐ Yes 2 Ø No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA	Oth	or f	of Death (Check			or (Specify)	
Division of	를 을 급	atlon: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date (Mon		28b. Time o Injury				28d. Des		w injury occur		
Divis	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not determined	280. Place	e of injury - At hing, etc. (Specif	ome, farm, str	reet, factory, of	fica		28f. Loca City	ation (Str or Town	reet and Numb , State)	er or Rurai i	Route Number,
	in 24 hour he Funer pletely fill	edical	29a. Certifier 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exe	miner: On tha b	e best of my kno esis of examina iner stated.	wledge, death tion and/or in	occurred at the vestigation, in	ne tir	ne, date and pinion, deat	d place, and due th occurred at the	to the ca time, da	use(s) and ma ate and place,	nner as stat and due to t	ted. he cause(s)
	To t Com	M	29b. Signatura and title of certifiar	91	noe	1	7	2	e number	55		ed. Date signed	12 0	a
			30. Name and address of phress, with	55 14 V	7F-1	36 8	Print)	ار	, s-	TREET	H	AGER	870 c	VN 170.
	Sta Registr		JUN 1 4 19	$99 \mid \stackrel{\scriptstyle 32.5}{\cancel{\wedge}} \mid$	egistrar's Signa	d.	Spac	K.						

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Deta of Death 3. Time of Counth Month **Physician** 1:11 m RENE 999 JUNE /Medical 4e Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Hagerstown

If Undar 24 Hrs. 8. Deta of Birth
(Month, Day, Year) Washington County Hospital Washington 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Undar 1 Yaer Birthplece (Stata or Foraign Country) **Funeral** Days 1 M 2 DF Months 84 Yrs. Director Oct.10,1914 Maryland 214-05-4009 death with the Marylend 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limite r then "natural", or items 23s or 28s-f show the Modical Examiner must be notified at 1XXYas 2□No Directo Maryland Washington Hagerstown 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Coda 268 South Potomac Street Funeral 21740 USA 14. Race - Amarican Indian, 12. Was Decedent Ever in U.S. Armed Forcas? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, etc.) 11. Maritel Status Bleck, Whita, atc. filed within 72 hours efter Yas 2 No 1 Nevar Married 2 Married Maryland 21215-0020 1 ☐ Yas 2X No Specify: White Specify: py 3X Widowed 4 Divorced Yeer or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Dacedant's Education (Specify only highest grade completed) 16b. Kind of Buainass/Industry Hygiene. Elamantary/Sacondary (0-12) Coilega (1-4or 5+) 12 Housewife Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important. If them \$7 is marked other any Injury or other traumatic event. 17. Fethar's Nama (First, Middla, Last) 18. Mothar'a Nama (First, Middle, Maiden Sumame) Be Clifton Lee Entler Gussie Mae Mose 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Barbara Hancock/Niece 12372 Big Pool Road Clear Spring, Maryland altimore, 20b. Plece of Disposition (Nema of cematery, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Buriai 2 Cramation 3 Ramoval from Stata Rest Haven Cemetery 6-24-99 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service License 022 Name and Address of Facility
OSborne Funeral Home 425 S. Conococheague Street Williamsport, MD 21795 a Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or have a lura. List only one ceuse on each line. Approximata Intervel Between Onset end Deetl **Physician** Myocardial infendion /Medical Immediete Ceuse (Finei 6 hours diseesa or condition rasuiting in death) Examiner Dua to (or es a consequence of): Examiner buriel-transit pue Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disaasa or Injury that initiated events rasulting in death) Last Due to (or as a consequence of): certificete be exec physicien s the buriel P.O. Box 68760. Physician/Medical Dua to (or as a consequence of): USB BS Jo Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Wera autopsy findings eveilabla prior to complation of cause of death? 24e. Was an eutopsy Completed performad' page 2 s hes 1 Tyes 2 PNO 1 □ Yes 2 □ No certificate Division of Vital Hospital or Attending Physician: director. Be 25. Was case rafarred to madical 26. Placa of Daath (Check only ona) Other: 4 Nursing Home 5 Residance 6 Other (Specify) 2 1 TYas 2 No 1 BInpatient 2 □ ER/Outpetient 3 □ DOA this funeral 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred Certification: After 5 Panding investigation 1 Natural after deeth. 1 Yas 2 No 2 Accident 6 Could not be detarmined 3 Suicida 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify) In by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and dua to the cause(s) end manner as stated.

2 Madicat Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and dua to the cause(s) and manner stated. 29e. Cartifian To the Hosp within 24 hou To the Fune completely fil edical (Check only one) 29b. Signeture end title of certifiar 29d. Date signed (Month, Day, Year) 29c. Licensa number

State Registrar 31. Deta fiiad (Month, Day, Year)

ZUBAIR H. FARIDI

JUN 2 3 1999

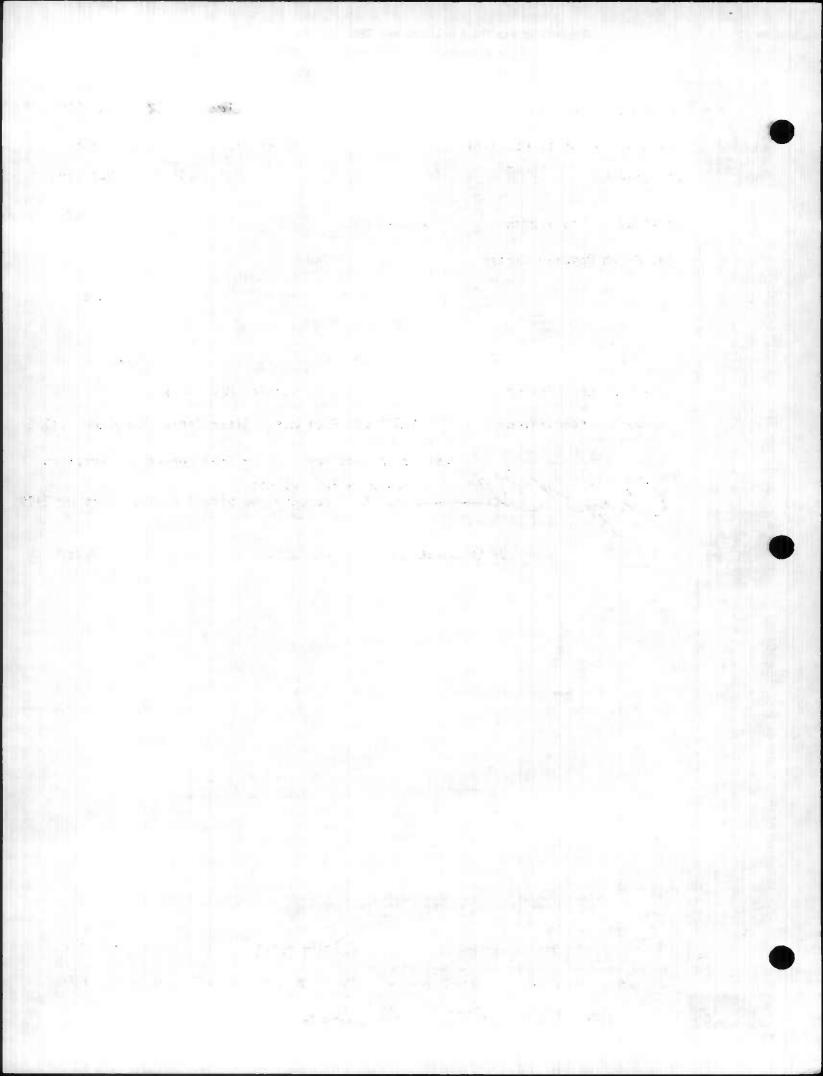
32. Registrar's Signetura

-columb

30. Nama and address of person who complated causa of daath (Itam 23a) (Type, Print)

249 MILL STREET HAGERS TOWN, MD 21740

6- 22-99

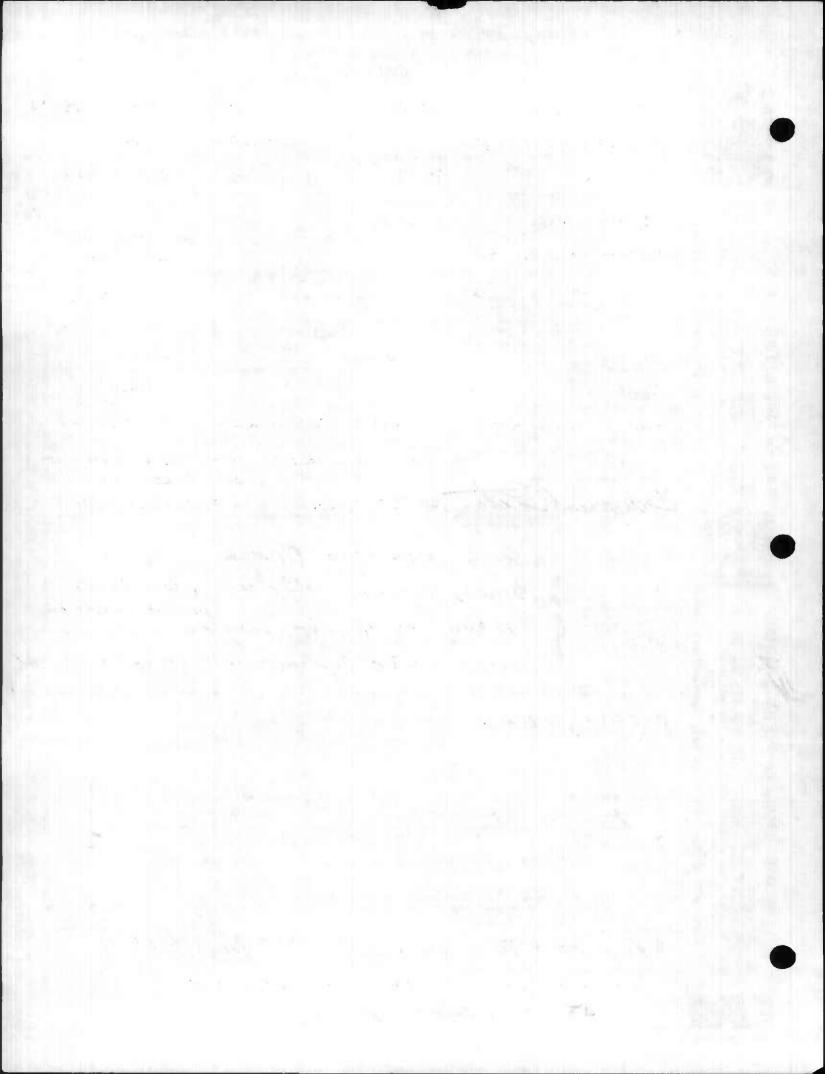


State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Data of Death 1 Decedant's Nama (First Middle Last 3. Time of Deeth JUNE 21, **Physician** 1999 COOLEY 4:25 AM LOUISE /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1 M M F Months Yrs Director 78 April 29,1921 217-16-2133 Maryland Usual Rasidance of Dacedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limita 28a-f ahow 7 is marked other than "natural", or itema 23s or 28a-f shot traumatic event, the Medical Examiner must be notified at 1 Yas 2 No Maryland Washington Boonsboro Direct 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 21859 Boonsboro Mt. Rd. permit. Pages 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or flama 23a and injury or other traumatic event, the Medical Example Traumatic United States Funeral 12. Wes Dacedent Ever In U.S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaer or Detes: 1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highest grade complated) 16h Kind of Rusiness/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) own home 11 Homemaker 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Minnick Viola Elmer 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) Jeannie Gaylor / daughter 21859 Boonsboro Mountain Rd./ Boonsboro, Md. 20e. Method of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 6-22-99 Hagerstown, Maryland Hagerstown Crematory 4 Donation 5 Other (Specify) 22. Nama and Addrass of Facility Stauffer Funeral Home 21. Signature of Funaral Sarvice Licansee 23a Panti Embrine disease, or complications that ceusad tha daath. Do not antar tha mode of dying, such as cardiac or respiratory errest, about, or hear failure. List only one cause on each line. 1621 Opossumtown Pike/ Frederick, MD 21702 Approximata Interval Batween Onset and Death Physician Immediata Causa (Final disaasa or condition rasulting in daath) /Medical · Sepsis - regp/24 tory Examiner colorosus, loostoux Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, laeding to immadiata ceusa. Entar Undarlying Causa (Disaasa or injury gongreve-sepsis. Volunters H was Box 68760 that initiated avants resulting in death) Last value Replesement on commedia 20241C ed by the a Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Denknown igned by ρλ 8 24b. Wera autopsy findings availabla prior to completion of ceuse of death? 24a. Was an autopsy Completed Deen hes 19 2 No 1 Yas 1 Yas 2 No certificate Division of Vital Physician: Be 25. Was cesa rafarred to medical 26. Pieca of Death (Check only one) 1 Yas 2 No Hospitel: Othar: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 10 Diractor: After this In by the funeral di 27. Mannar of Daath 28d. Dascribe how injury occurred Certification: offer death. 1 Natural 2 Accidant 5 Panding Investigation 1 Yas 2 No 3 Suicide 6 Could not be 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify) 28f. Location (Streat and Number or Rural Route Number, City or Town, Stata) 4 Homicida hin 24 hours e the Funeral D npletely filled Hospital 1 Cartifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es ateted.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) edical 29a Cartifian within 2 To the collapse number cell 2 29b. Signature and title of certifiar 29d. Date signed (Month, Day, Year) 0 Nichotas 8. Sous mo 30. Nama and addrass of person who complated ceuse of deeth (Item 23a) (Type, Print) Nicholas Ρ. Foris, MD / 74 Thomas Johnson Dr./ Frederick, MD.

State Registrar 31. Data filad (Month, Day, Year)

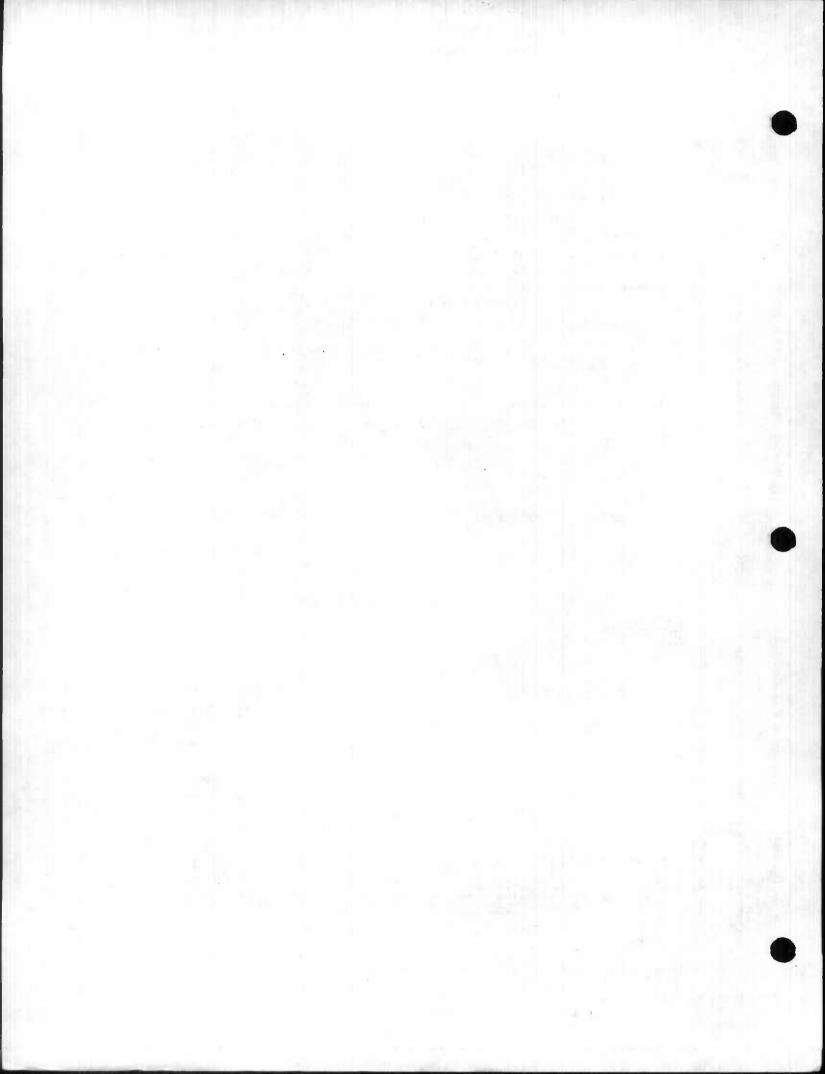
32. Registro Signatura

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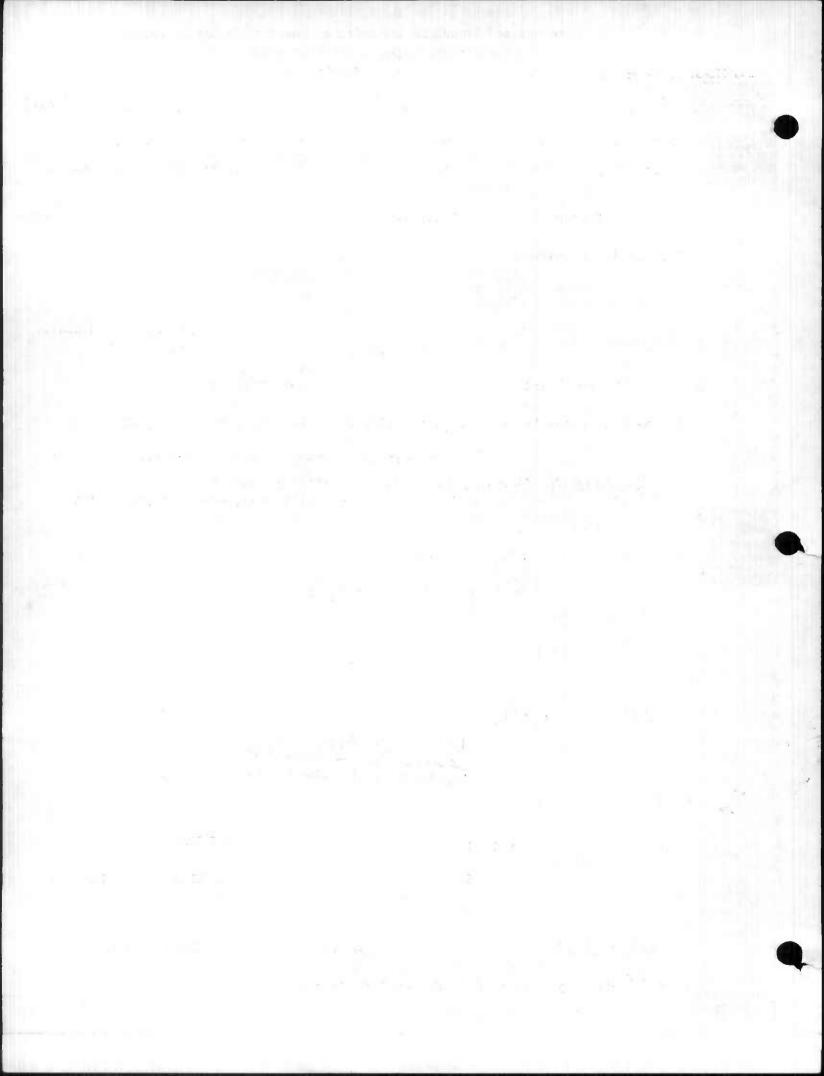
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n						Ce	rtificate	of L	eath			Reg. No.	(	1002	
61		1. Decedent's Neme (First	, Middle, L.	nst)	TO NOT	117					2. Date of Dea	lth Day	Year	3. Time of Deat	th
Physici /Medic		JERRY	T	UCKER	CRUM						June		999	11:22 A	AM.
Examin		4s Facility Name (If not in	stitution, gi	ve street and num	nber)			41	. City, To	wn, or Loc	cation of Death	4c. County	of Death		
		4	703 M	ussetter	Road	#4				amsv:			ederi		
Funeral Director		5. Social Security Number 213-42-1995 Usual Residence of Deced		Sex 1 M 2 □ F	7. Age (In yrs	: last birthday Yrs.	Months D	ear ays	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Jan . 8	, Year) 1944	9. Birtho Coun Mary	ace (State or Fording) Land	eign
A BM		10a. State 10b.	County		10c. C	ity, Town or L	ocation						11	Od. Inside City Lim	nits
the Maryland 28e-f show notified at	Director		reder	ick	I	jamsvi								1   Yes 2 2	No
th with		10e. Street and Number 4703 Muss	etter	Road A	pt. #4			175				United	Stat	es	
21215-0020 d within 72 hours after des glers. yet then heature?, or terms the Medical Examiner m	by Funeral	11. Merital Stetus  1 □ Never Merried 2  3 □ Widowed 4 ☒ Di	T - 111	12. Was Dece Armed For 1 [X] Yes If Yes, Give Year or De	ces? 2 No	u,s. 13.	Was Decedent If Yes, specify 1 ☐ Yes 200 €		spanic Ori n, Mexicar Specify:	gin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)	14. Rac Bla Specif	ce - Americ ck, White, ov v: Whi	etc.	
5-0 72 Tr	Completed	15. Do	cedent's E	ducation ade completed)		16a. Dece	dent's Usual O	ccupa lone di	tion urina mos	t of workin	a l	16b. Kind of B	usiness/Ind	ustry	
121 willhin then	d d	Elementary/Secondary (	1	College (1-	4or 5+)		kind of work d DO NOT use n								
d 2 Hygier H, H		12	41-4-41-4	1		Elec	tronic				455		htel		
E 2305	Be	17. Father's Name (First, M										Maiden Sumer			
Should and Marks	2	Robert L  198. Informant's Name/Re				105 84-3	inn Address (C)					a Tucke		Codel	
Mar d 2 sh th and 7 is m		Karen E. Wi			20		ing Address (Si								
Te, N Tand Health Sm 27		20a. Method of Disposition		daugnice	20b.	Place of Disp	Carria	of		rrec	Date Date	Maryla 20c. Location			
Baltimore emit. Pages 1. Appartment of He mportant: If then ny injury or oth nice.		1 Burial 2 Crem 4 Donation 5 DO	her (Speci	fy)	itate   essi	. Oliv	et Ceme	tei	су			Freder	ick,	Maryland	d
Ball Depart Import any in		21. Signature of Funeral S	ervice Lice	1			<ol> <li>Name and A</li> <li>Opc</li> </ol>							, P.A. Land 2170	02
Medical Examiner by physician and burial-transit as the burial-transit	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition if any, leeding to immedia cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last	<b>. .</b>	a. Const	Due to (	or as a conse	quence of):	1)9		shot	M	\$ 5/h	600		
P.O. Box ( hat the death certif d by the attending detached for use a	by Physician/Med	Part II. Other significant o	onditions	d	ath but not re	sulting in the u	inderlying caus	e give	n in Part I			obacco use co	ntribute to	the cause of dea	
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The lay	Com										1 52/	es 2 No	1,5	Yes 2□ No	
	Be	25. Was case referred to n	nedical						26. Place	of Death	(Check only o	ne)			
- Z = 0	2	1 Yes 2 No		Hospitel: 1 🗆 In	patient 2	] ER/Outpatie	nt 3 DOA	Othe	r: 4□ Nu	rsing Hom		ence 6 Oth		)	
On O ding Ph h. After thi funeral	- uo	27. Manner of Death  1 Netural 5	Pending	28a. Dete of (Month)	f Injury , <i>Day Year</i> )	28b. Time of finjury		Injury Work			8d. Describe h	ow injury occur	red		
Division  or Attending after death.  Director: After d in by the fune	Certification:	2 Accident	nvestigatio	VV	NK	LINK	М		es 2 🖄		major	stor	SEY		
Division or Attend after death I Director: /	틭	4 Homicide	determined	200. Place (	of Injury - At I g, etc. (Speci	nome, farm, st	reet, factory, of	fice			City or Tow	n. Stete)	ber or Hura	I Route Number,	
Division  To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical Ce	29e. Certifier 1 ☐ Ci (Check only 2 ☐ Me	ortifying Pr	nysician: To the b	pest of my knosis of examina	owledge, deat	h occurred et th	ne time	e, date an	d place a	1763 Mund due to the d	ause(s) end m	enner as at	ated.	
To the I	_		/	and manne	er stated.										
C X C S	77	29b. Signetule and title of		2			29¢. Li	uerise	number			29d. Date signe	l (Month, I	ray, rear)	
		1	K	M	_			0.0	.M.E			6/	19/	99	
		30. Name and address of p	Who who	WIXOR	V	111	Print) Penn St	ree	t, B	altim	nore, M	aryland	2120	1	
Sta Registra		31. Date filed (Month, Day,	UN 2	2 1999 ▶	glstra s Sign	ature	B.	de	ak.						



	AMEND IT	MS:	#28A-F PER MEO G77			Department of F Certificate of I			giene 9 (	3 2	1083
	Physic /Medi	ian	1. Decedent's Name (First, Midd	HAINES	CA	NNON		2. Date of De Month	Day	Yaar 99	3. Time of Death 5 10 pm
	Exami	ner	4a. Facility Nama (If not institution			10.1	4b. City, Town, or Loc			y of Death	
1	Francis		North Hampton  5. Social Security Number	6. Sex 7. Age	g Home	hday) If Under 1 Yaar	Frederick If Under 24 Hrs.	8. Date of Bir		derick	aca (Stata or Foreign
	Funeral Director		220-18-1599	1□ M 21 F		rs. Months Days	Hours Min	May 24	1911	Bruns	wick MD
	pue M.		Usual Residence of Decedent 10a. Stata 10b. County	,	10c. City, Towr	or Location				10	Od. Inside City Limits
	the Meryler 28s-f show	to	MD Fred	erick	Knoxvi						1 ☐ Yes 2√ No
ì	or 28s	Olrec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
	23a	rai	3322 Carlisle	Drive		2175	8		USA		
020	ors after de	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Mar  3 ☐ Widowed 4 ※ Divorced	If Ves Give		13. Was Decedent of H If Yas, specify Cubs 1 ☐ Yes 2 ☑ No	fispanic Origin? (Spean, Mexican, Puerto F Specify:	cify Yes or No Rican, atc.)		ce - Americ ck, White, by:	
Baltimore, Maryland 21215-0020	permit. Peges 1 and 2 should be filed within 72 hours after death with the Merylend Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show important: if Item 27 is marked other than "had sale a remines must be notified at once.	Be Completed	(Spacify only highs Elementary/Secondary (0-12)	nt's Education est grada complatad) College (1-4or 5+	-)	Decedent's Usual Occup (Giva kind of work dona of lifa. DO NOT usa retired	pation during most of worklind)	g	Jim Hai	ley C	hevrolet
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/lan	Aental Aental rked o	ToB	Henry Hamilton	Haines			Emma Grad				
Aan	2 sho and I is me		19a. Informant's Name/Relations			Mailing Address (Street			-		Coda)
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Baltin	permit. F Departm Importar any fnjur		21. Signature of Fundal Service	Ligorisee Wille	ame	JOHN T. WI	ss of Facility Thams Fur	neral H	lome		
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	Physician /Medical Examiner		Immediate Ceuse (Final disaase or condition	only one cause on each line	norua						Interval Between Onsat and Death
	LAMIMICI	-e	resulting In death)	@f.	Due to (or as e c	onsequence of):	100	-			ZwKS
	outed ansit	dical Examiner	Sequentially list conditions	· ary	Oue to (or as a c	5/27	177			i	30.4
90,	cete be executed physician end the burial-transit	Ex	Sequentially list conditions, if any, leading to Immediate causa. Enter Underlying Cause (Disease or Injury			51150435102 517.					
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	the ette	sicia	Part II. Other algnificant condition	ons contributing to death but	not resulting in	the underlying cause giv	ren in Pert I	23b. Did (	obacco use cr	entribute to	the cause of death?
P.O.	that the de ad by the detached	Physician/M	CVA	6/1/99	•	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1 🗆			ably 4 Unknown
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Ş	ysiclar is certif	o Be	25. Wes case referred to medica examiner?  1 ✓ Yes 2 ☐ No	Hospital:	t 2 ER/Out	patient 3 DOA Oth	26. Plece of Deeth er: 42 Nursing Hom			os (Cossil	
Joh	Attending Physician: or death. ector: After this certific by the funeral director,	n: T	27. Manner of Death	28a. Date of Injury	28b. T				now Injury occur		/
Siol	leath. lor: Aff the fu	catic	1 Natural 5 Pendir	gation June 17, 1		A 17 1	Yes 2 No S	UBJECT F	ELL.		
Division of Vital	I or Attendi efter death Director: A d in by the f	Certification:	3 Suicide 6 Could 4 Homicide determ	28e. Plece of Injury building, etc.	y - At home, far (Specify)	m, street, factory, offica	J	City or Tov	Street end Num. vn, Steta) ISLE DR.		Routa Number,
	Hospital 24 hours Funeral I	Sal	29a. Certifler 1 ☐ Certifylr	ng Physician: To the best of	my knowledge,	death occurred at the tim	ne, date and place, a	nd due to the	ceuse(s) end m	enner es st	ated.
	To the Hospital or I within 24 hours effer To the Funeral Director Completely filled in the Internation of t	ledical	one)	and manner stete	examination and	or investigation, in my of	pinion, deeth occurre	d at the time,	date and place,	and due to	the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certifie	ſ		29c. License			29d. Data signe	0-0	Day, Year)
			and West		-16. fat	D26816			IUNE 18	1999	
			30. Name and address of person	who completed cause of dee	etn (Item 23a) (1	PRED US 217	02				
	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	s Signature	4	/				
	Registr	ar	JUN	2 1 1999	~, 11 4	. p. pp	Docker				

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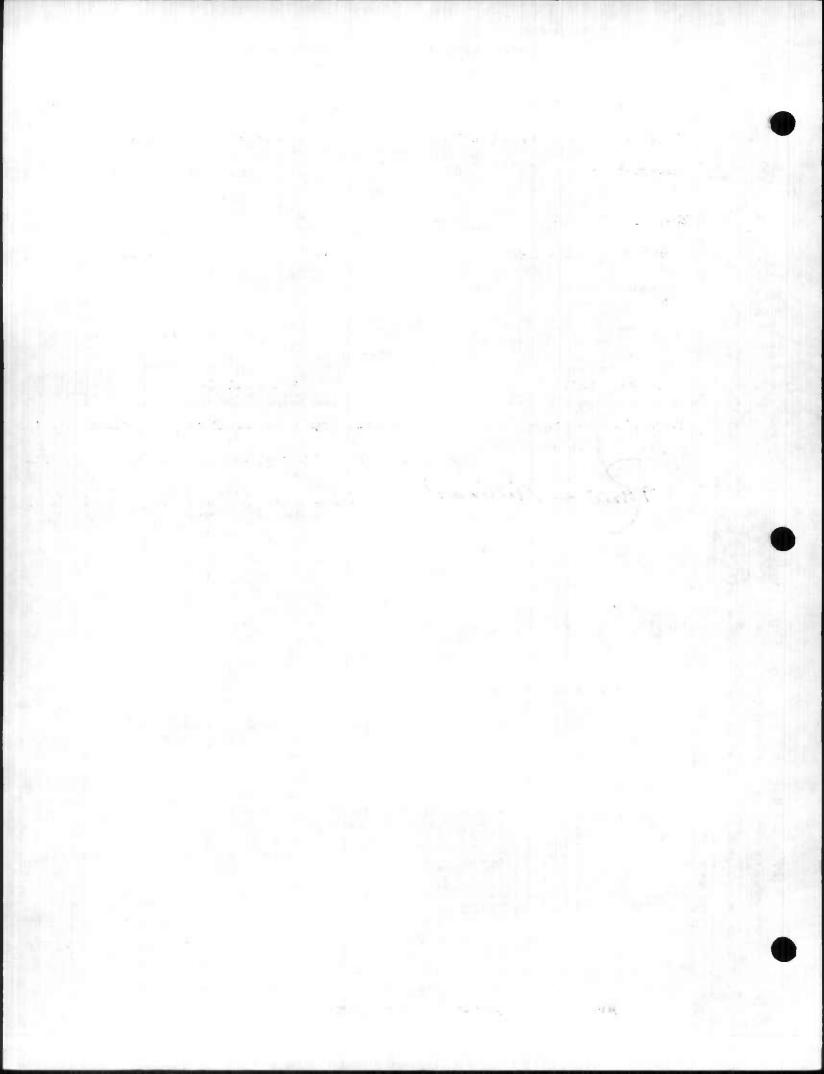


State of Maryland / Department of Health and Mental Hygiene 9

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 15:50 Daisy B. DaCosta 16 1999 June /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll County General Hospital Westminster Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 10 M 28 F 062-30-8329 85 Director Nov. 23, 1913 Jamacia Usual Residence of Decedent with the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Carrol1 Mount Airy 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6627 Wind Ridge Road 21771 U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. pernit. Peges 1 and 2 should be filed within 72 hours after to Department of Heelth and Mental Hygiene. Important: If tem 27 is marked other than "natural", or free may injury or other traumatic event, tra Medical Examine Boos. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: p 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Private Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Hilda Llado Russell Hall 19a. tnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald M. DaCosta - Son 6627 Wind Ridge Road, Mount Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete on 5 Other (Specify) Royal Palm North Cemetery 6/22/99 St. Petersburg, Fla. 21. Signature of Fungral Service Licensee 22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home overt 26401 Ridge Road, Damascus, Maryalnd 20872-0117 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Ceuse (Finel 2 days fneu monia diseese or condition resulting In death) Examiner Due to (or es a consequence of): Examiner physicien and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Dissess or Injury that initiated events resulting In death) Lest Due to (or es e consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): P.O. Pert tl. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funerel Director: After this certifical stely filled in by the funeral director, 25. Was case referred to medical 8 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 Neturel 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number M.D. xia trim, D52479 June , 16, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LISA KTM, M.D. at Carroll County Hospital 200 memorial Avenue, Westminster, MD 21157 32. Registrer's Signature State Registrar

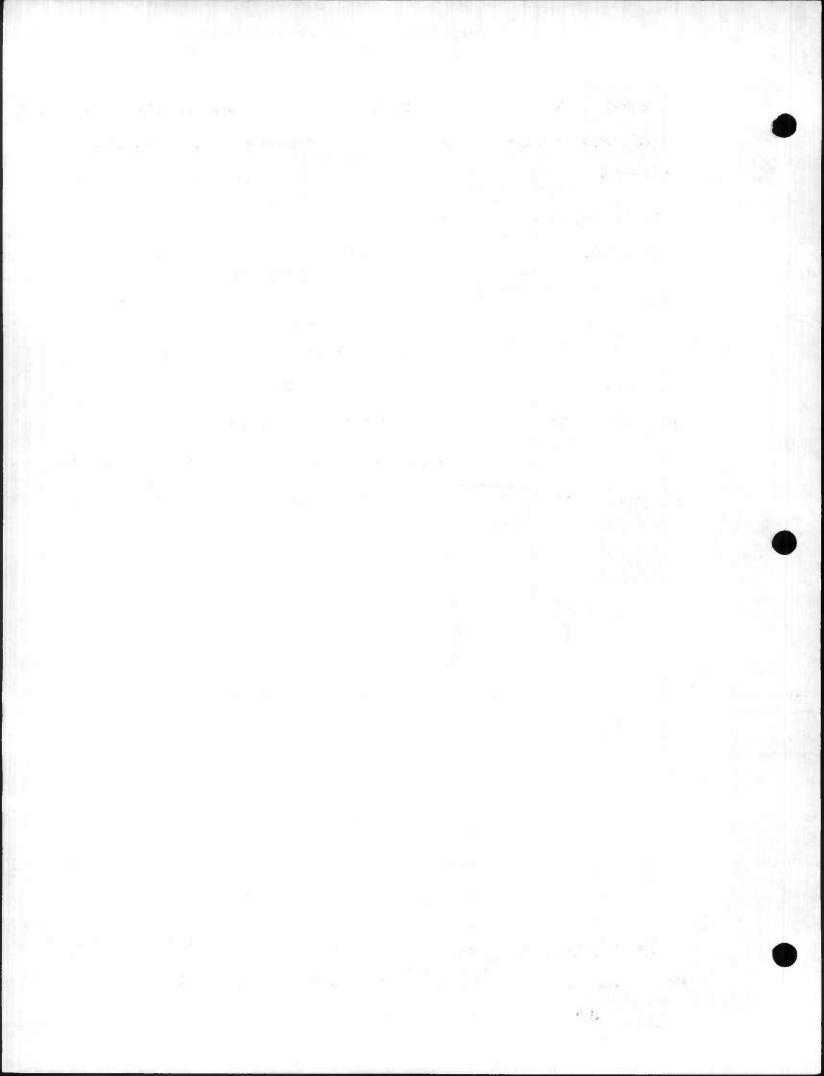
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State of Maryland / Department of Health and Mental Hygiene

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			Frederick Heal	th Care	Center				Frederi			Fre	deric	:k	
	Funeral Director		5. Social Security Number 6. 214-30-1652  Usual Residence of Decedent	Sex 1√2 M 2□ F	7. Aga (In yrs	s. last birthday) Yrs.	Month	ler 1 Yae s Days			ау, төв	n) 1934			ete or Foreign
	land land		10a. Stata 10b. County		10c. C	ity, Town or Lo	ocation		··· <u>-</u>				1	0d. tnsic	de City Limits
	the Mary 28a-f eh	Director	Maryland Freder	ick	Т	hurmont									Yas 3/3/No
	ath with 1 23a or 3		10840B Powell	Road				Zip Coda 21788	3		10g. (	U.S.	What Cour	itry?	
Maryland 21215-0020	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show the Micklest Examinet must be notified at	by Funeral	11. Maritei Status  1 Nevar Married ANMerried 3 Widowed 4 Divorced	Armed F	2⊠ No ive		if Yes, s	edant of becify Cul	Hispanic Origin? (!ban, Maxican, Pue	Specify Yes or Norto Rican, etc.)	0-	Bie	ze - Americ ck, Whita, y: whi	etc.	n,
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an	0 2 0 0	o Be	Robert W. Eaton						100000000000000000000000000000000000000	ine Mc H					
ary	d 2 should be the and Menta T is marked traumatic events.	1	19a. Informant's Neme/Ralationship	(Type, Print)		19b. Maiii	ng Addra	ss (Stree	et and Number or F	Rural Routa Numb	per. Cit	v or Town	Stata. Zip	Code)	
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altimore,	Pages 1 and 2 nent of Health and: If Item 27 is ary or other tra		20a. Mathod of Disposition			Place of Dispo	sition (A	lama of		Deta	_	-	City or To	wn, Stat	ia
E	Page net: H int: H		Suriat 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Othar (Spec			thaven			•	6/23/99	Fre	deri	ck. M	arv1	and
aiti	permit. Pages Department of Important: If It any Injury or office.		21. Signature of Funarai Sarvica Lic	ensee					and of Facility	Stauffer					
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on	ding.	tio.	1 Naturai 5 ☐ Panding 2 ☐ Accidant invastigati	(Mor	ith, Day Year)	injury	M	28c. Inju Wo	ork? ⊒Yas 2 ⊒No	200, 200, 100		,01, 00001			
Division	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicida 6 Could not datarmine	20a, Place	e of Injury - At I ing, atc. (Spec	noma, farm, str ify)	reet, facto	ory, office	)	28f. Location ( City or To	(Street wn, Sta	an <i>d Numt</i> ata)	ber or Rura	l Routa i	Number,
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	To the To the comp	Me	29b. Signature end titla of certifier				2	9c. Licen	se number		29d. [	Date signe	d (Month,	Day, Yes	ar)
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			30. Nama and addrass of person who	complated cau	sa of daath (tte	m 23a) (Type.	Print)						•		
			MELL WARANDEICH		1475	TANEY	AVZ	H-2	.04 FREA	FRICK, 1	MD	21	SOF		
	Sta	te	31. Data filed (Month, Day, Year)		Registrer's Sign	atura	-								



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JAMES PAUL ENRIGHT JUNE 12:30 A.M. 1999 4e Fecility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Yaar If Under 24 Hrs. 8. Dete of Birth Months Days Hours Min. (Month, Day, Year) 5. Sociel Sacurity Number 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) 1 M 2□ F Months Days Hours Yrs. 184-24-8101 Jan. 18. 1931 Pennsylvania 68 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. fnside City Limita 1 □YYas 2 □ No Maruland Frederick Emmitsburg 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 45 Park Drive United States 11. Maritai Stetus 12. Was Decedant Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married 1 Yes 2 XNo Specify: 3 ☐ Widowed 4 ☐ Divorced white Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Air Conditioner Elementary/Secondary (0-12) College (1-4or 5+) 12 Chief Inspector Manufacturer 18. Mothar's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Alberta Elizabeth Brennan James Enright 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth C. Enright - wife 45 Park Drive, Emmitsburg, Maryland 21727 20b. Place of Disposition (Name of cematery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Mother of Sorrows 6/22/99 Finch Hill. PA 22. Name and Address of Fecility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. MD 21788 Approximate tnterval Between Onsat and Daath tmmediete Cause (Final PNeumonia disaase or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initialed events resulting in deeth) Lest Due to (or ea e consequence of): Due to (or as a consaguanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cances 24b. Were eutopsy findinga available prior to 24e. Wea en eutopsy performed? completion of cause of deeth?

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a State

Directo

Funeral

py

Completed

**Funeral** 

Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel hygiena. Important: If item 27 is marked other than "natures" any injury or other traumatic averages.

physician and the burial-transit USB signed by the e page 2 certificate director, After this funeral

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

24 hours after death.

Funeral Director: A

within 2 To the To the

Examiner Physician/Medical by Completed Be 2 Certification:

1 Yes 25 No

1 Yea 2 No

26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 Yes 2 No

fred

281. Location (Street and Number or Rural Route Number, City or Town, State) Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(a) and menner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

(Check only one) 29b. Signeture and titla of certifiar

25. Wea casa referred to medicel

1 Yes 2 No

27. Menner of Deeth

Neturel

2 Accident

4 Homicide

3 ☐ Sulcide

29a. Cartifiar

29c. Licensa number

28c. Injury et Work?

29d. Data signed (Month, Day, Year)

5 Panding

Investigation

6 Could not be determined

MO

MO 51610

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

AUR 1475

2. Registrars Signature 31. Dete filed (Month, Dey, Year) JUN 2 1 1999

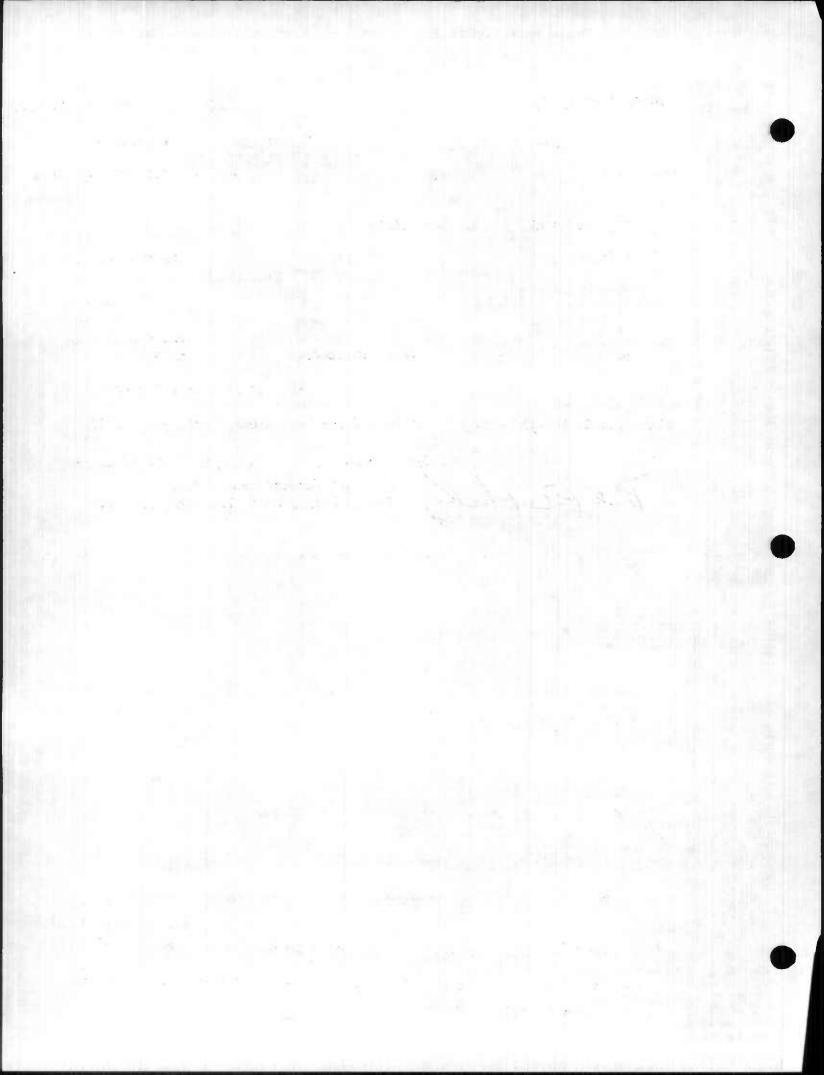
Inpatient 2 ER/Outpatient 3 DOA

Plece of Injury - At home, ferm, streat, factory, office building, atc. (Specify)

28b. Tima of

State Registrar

Medical



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Susan Fog1e Martha June 19,1999 10:10 A.M. 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Frederick Memorial Hospital Frederick Frederick 8. Dete of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours 1 □ M 2 1 F 214-46-7193 Yrs. 52 May 20, 1947 Virginia Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Frederick Maryland Frederick 11 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 916 Pine Avenue 21701 U.S.A. 14. Raca - American Indien, Biack, White, etc. 11. Marifel Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 Yes 2 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 18a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent'a Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary/Off Mgr Health Care Office 18. Mothar's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Kenneth Russell DAME Martha PHILLIPS Anna 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr David A. Fogle/Husband 916 Pine Avenue, Frederick, Maryland 21701 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory Jun 20,1999 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture Funerel Service Licenses 22. Name end Address of Facility Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701 Pa 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one ceuse on each line. Approximate interval Between Onset and Deeth Immediata Causa (Final disease or condition resulting in death) METASTATIC CARCINOSARCOMA OF THE UTERUS 20 MONTHS Due to (or as e consequance of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lesf Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Was an autopsy performed? 25. Was case raferred to medicel axaminer? 26. Place of Death (Check only one) Hospital: 1 Manpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 25 No Othar: 4 Nursing Home 5 Residence 8 Other (Specify) 27. Mannar of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Yaar) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

Director

Funeral

by

**Funeral** 

Director

7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examinar main be notified at

the Meryland

death

Peges 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.

Hygiene.

h end Mental I

item 27 I

permit. Peges Department of Important: If it any injury or c

Examiner physician end the buriel-transit The law requires that the deeth certificate be executed signed by t d be detech

s certificate hes b director, pege 2 s director. funerel

Physician/Medical by Completed Be Certification: To

Medical

Hospital or Attending Physician: this After death. efter death Director: / d in by the f in 24 hour the Funerel Directory within 24 hou To the Funel completely fil

To the

Division of Vital Records, P.O.

29a. Certifier

3 ☐ Suicide

4 HomicIda

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and title of certifier

6 Could not be determined

29c. License number D31761 29d. Date signed (Month, Dey, Year)

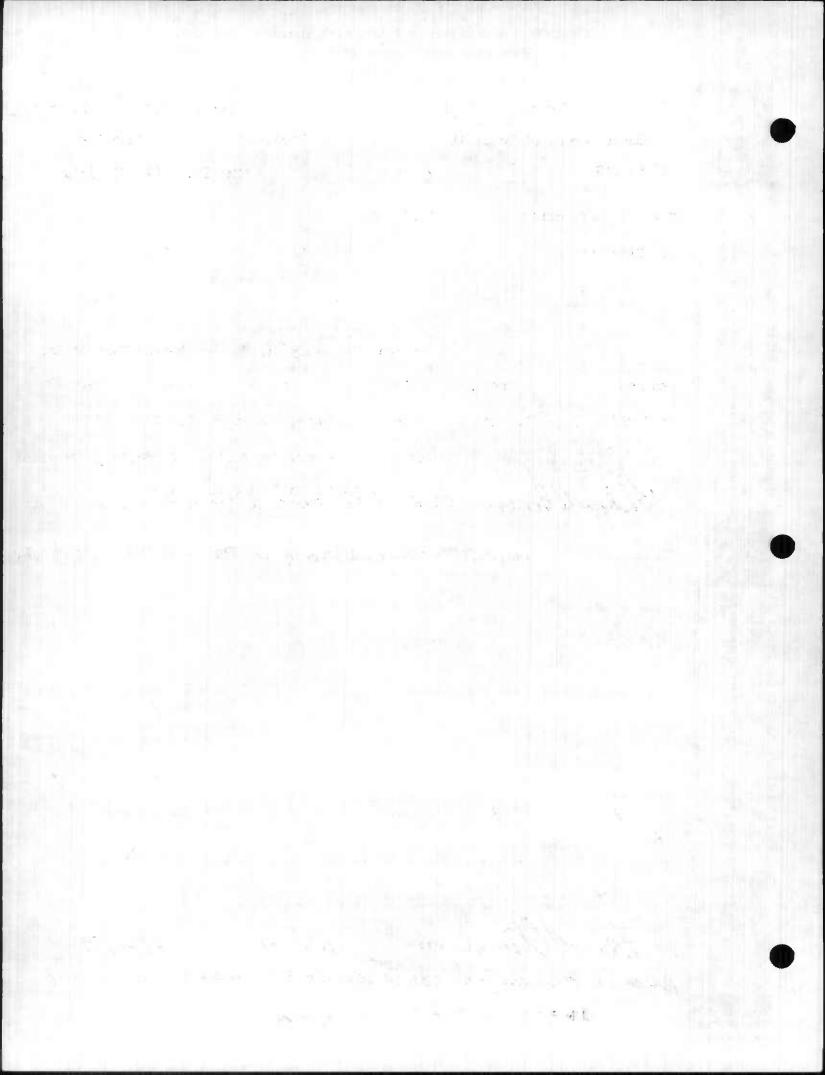
Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed ceuse of death (Itam 23a) (Type, Print)

RUAN M. & GNNOR MD SOI W. SEVENTH ST. FREDERICK, MD 31. Dete filed (Month, Day, Year)

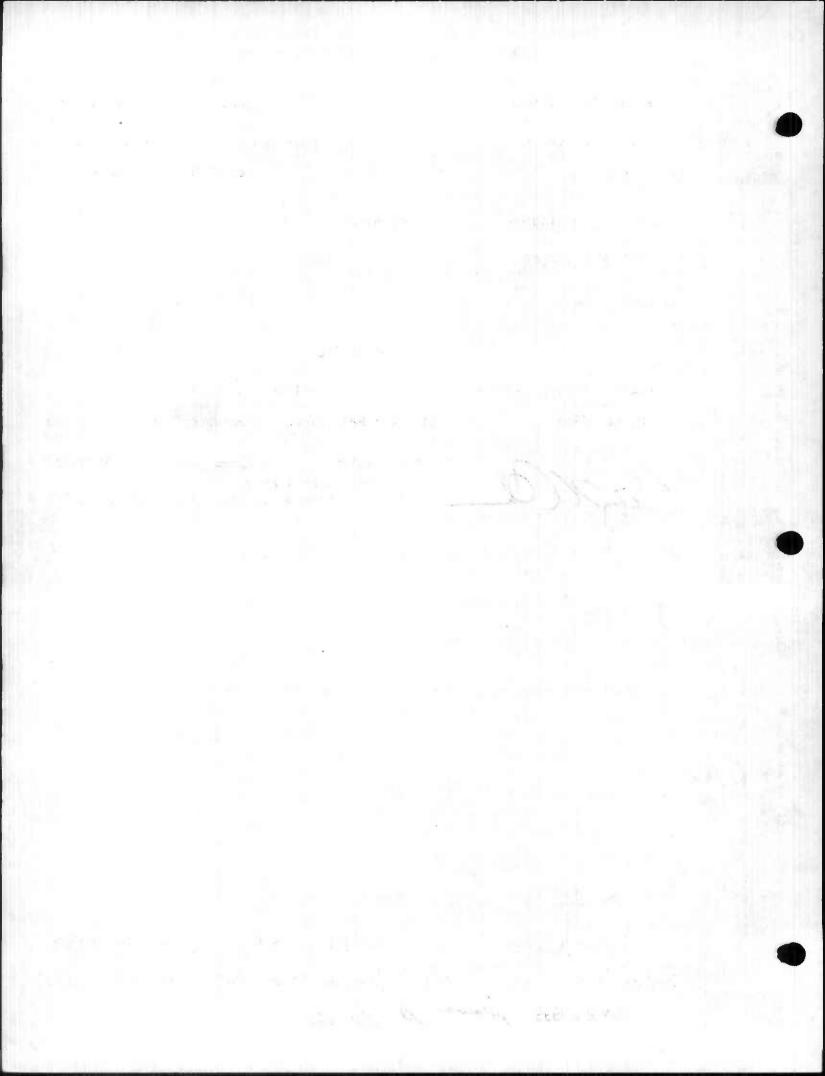
28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify)

State Registrar



				State of Marylar		artment of I rtificate of			giene 9	9 2	21088
	Physic /Medi		1. Decedent's Nama (First, Middle, Las Esther May G	amper				2. Data of Da Month June		1 9999	3. Time of Death 6:30 AM
	Funeral Director		4a. Facility Nama ( <i>If not institution</i> , <i>giva</i> 215 West Main Str  5. Social Security Numbar  214-09-4570	eet	. last birthday) 88 Yrs.	If Undar 1 Yaar Months Days	4b. City, Town, o Sharps If Under 24 Hr Hours Mid	s. 8. Data of Bir	Wa	ash i no	iton aca (Stata or Foraign y Land
21215-0020	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28s-f show the Madical Examinet must be notified at	Completed by Funeral Director	Usual Rasidanca of Dacadant  10a. State  10b. County  Maryland  Washi  10e. Sfraat and Numbar  215 West Main Str  11. Marital Status  1 Navar Marriad  (Specify only highast grade Elamentary/Secondary (0-12)	ngton  12. Was Decedant Evar in L Armed Forces () 1	J,S. 13. \	psburg 10f. Zip Coda 2	Specify:	Specify Yas or No into Rican, atc.)	- 14. Rac	What Count  USA  De - Amarica  ck, Whita, a	in Indian, itc. Ihite
Maryland	d 2 should be filed th and Mental Hygi 7 Is marked other treumatic event,	To Be Con	8 17. Father's Nama (First, Middle, Last) Augustus Asbur 19a. Informant's Name/Ralationship (7) Carl H. Hebb/Son	y Hebb		Housewing Address (Straat	18. Mothar's Na Nettie	Rural Routa Numb	etzel er, City or Town,	State, Zip	Coda) 21782
Baltimore,	permit. Pages 1 en Department of Heal Important: If item 2 any Injury or other 2005.		20a. Mathod of Disposition  1 💢 Buriai 2 Cramation 3 F  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Ligans	Ramoval from Stata MT	View 22 03 425		y ass of Facility unerally ococheag	ue St.Wi	lliamspo	ourg,M	laryland
,	Physician /Medical Examiner physician end physician end physician end physician end physician structure in the principle of the physician structure of the p	dical Examiner	23a. Partf. Entar the disease, or complishook, or heart for ura. List only of immediate Cause (Final disease or condition rasulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Inlitiated avents resulting in death) Last	Due to (c		Cardial uence of): heary uanca of): tension		chen' Sease	rrast,		Approximate interval Between Onsaf and Death  2 HRS  Menowh  1 Exps
necolds, r.O. Box oc	requires that the death certifi een signed by the ettanding hould be detached for use es	Completed by Physician/Med	Part II. Other significant conditions con	J	sulting In the un		ven in Part i.	1		3 Probe	the cause of death?  ably 4 Unknown  e autopsy findings labla prior to pletion of cause aath?
Vilal	Attending Physicien: The lew redeath. ector: After this certificate has b by the funeral director, paga 2 s by the funeral director, paga 2 s	To Be	27. Mannar of Daath	fospital: 1 ☐ inpatiant 2 ☐ 28a. Date of injury	28b. Tima of	t 3□ DOA Oth	nar: 4 ☐ Nursing	aath (Check only o		1 □	Yas 2□ No
DIVISION	To the Hospital or Attending Physical With 24 hours after death.  To the Funerel Director: After this completaly filled in by the funeral directors.	Certification:	1 Naturai 5 Panding Invastigation 3 Suicida 4 Homicida 6 Could not ba detarmined	(Month, Day Yaar)  28e. Placa of Injury - At his building, atc. (Specif.		M 1 □	Yas 2 □ No	City or To			
	To the Hosp within 24 hor To the Fune completaly fi	Medical	29b. Signatura and fitta of certifiar	alcian: To the bast of my kno ner: On the basis of examina and mannar stated.	tion and/or invi	astigation, in my o	pinion, death occ	a, and dua to tha urred at the time,	date and placa, 29d. Data signe	and due to t	ha cause(s)
	Sta Registra		30. Nama and address of parson who co 2 a f a   \( \text{\text{Call Resonant Parson}} \) 31. Data filed (Month, Day, Year)  JUN 2 2 199	32. Ragietrar's Signa	0311	Printappa	ns Rd	Boor	sbow	мр	21713

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 99

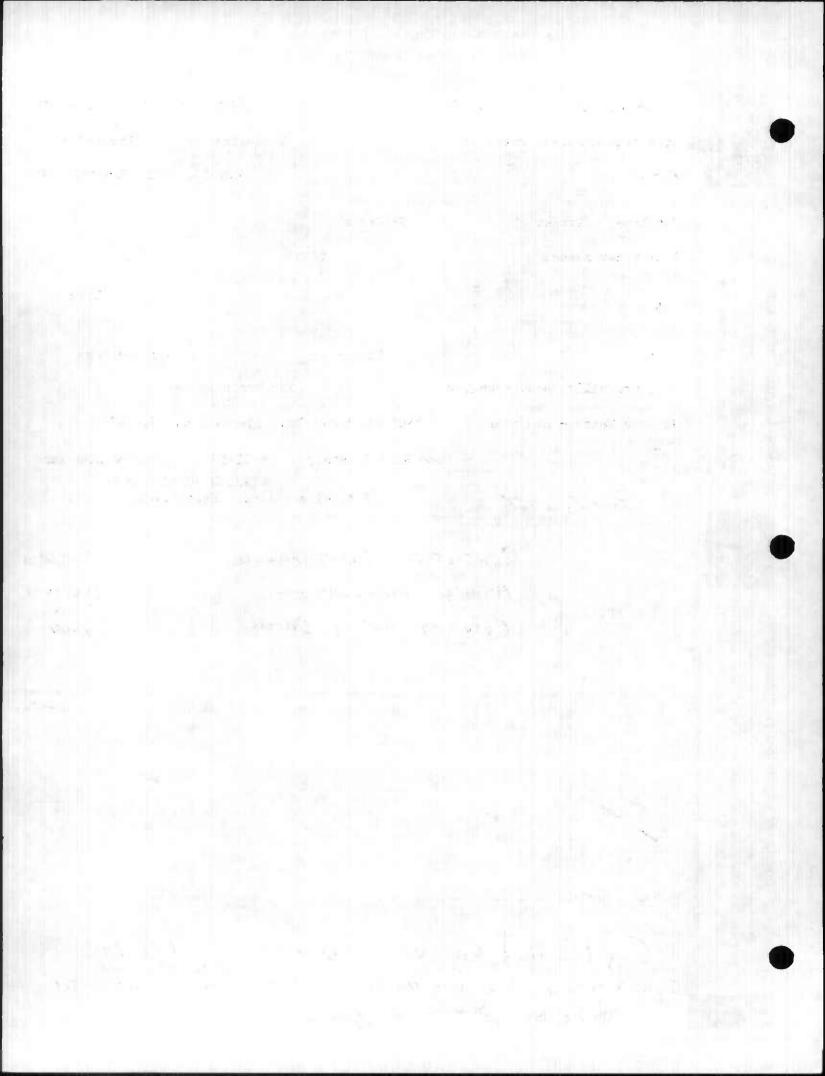
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		C	ertificate of	Death	R	eg. No.			
Decedent's Name (First, Middle, L.	ast)				2. Dete of Deel	th	Vans	3. Time of Death	
lan NELLE Ann	GEAR	Y			JUNE" 19	9, <sup>Da</sup> 1999	Yeer 3	5:50 AM	
4e Facility Neme (If not institution, g	ve street end number)			4b. City, Town, or	Location of Death	4c. County	of Deeth		
Frederick Memoria	al Hospital			Fred	erick		Freder	ick	
		n yrs. lest birthda	Months Devs			Year)	9. Birthplac	ce (Stete or Foreign	
220-52-1643	1 M 2 S F	38 Yrs	inomia coy.	TIOUTS IVIII.	May 28,	1911		ylvania	
Usuel Residence of Decedent		01. T	1 da-				Land	1 11 65 11 5	
10e. Sfefe 10b. County		c. City, Town or	Location				10d	I. Inside City Limits  1X Yes 2 □ No	
§ Maryland Fred	erick	F	rederick					14D Yes 2 No	
Maryland Fred 10e. Sfreef end Number			10f. Zip Code		1	Og. Citizen of V	Vhet Country	?	
1421 Taney Avenue	е			21702		U	SA		
11. Maritel Status	12. Wes Decedent Eve Armed Forces?	r in U,S. 1	<ol><li>Was Decedent of If Yes, specify Cu</li></ol>	Hispenic Origin? (S	pecify Yes or No- to Rican, etc.)		e - American ck, White, etc		
3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🖾 No If Yes, Give Year or Detes:		1 ☐ Yes 2 ☒ No			Specify: White			
15. Decedent's E (Specify only highest g	ducation	16a. De	cedent's Usuel Occu	upation	delaa	16b. Kind of Bu	siness/Indus	stry	
Elementary/Secondary (0-12)	College (1-4or 5+)	life	DO NOT use retir	ed)	King				
12	3		homemak	er		her o	wn hom	ne	
17. Fether's Neme (First, Middle, Las	t)			18. Mother's Ner	me (First, Middle, I	Meiden Sumam	10)		
Dr. Granville M	oody Brubake	r		Ida M	arie Stor	ner			
19e. informent's Name/Reletionship	(Type, Print)	19b. M	alling Address (Stree	et end Number or Re	urel Route Number	r, City or Town,	State, Zip Co	ode)	
Susanne Geary -	daughter	360	3 Big Wood	ds Rd., I	jamsvill	e, Md.	21754		
20e. Method of Disposition		20b. Plece of Di	sposition (Neme of cremetory or other pl	iaca)	Dete	20c. Location -	City or Town	ı, State	
1 ☑ Buriel 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Spec			11 Cemete		-22-99	Hagerst	own M	aryland	
21. Signeture of Funeral Servica Lice			22. Neme end Add	-	INNICH FU			, , , , , , , , , , , , , , , , , , , ,	
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23a. Pert1. Enter the disease, or cor	estel	death Death						pproximete	
disease or condition resulting in deeth)  Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underlying Couse (Disease or injury	b. ATRIA	to (or es a con F to (or es e con	iBLILLA.				F	EW DAYS EW DAY EVERA-	
that Initiated events resulting in death) Lest	that Initiated events								
A p					24e. Was e	en eutopsy	24b. Were	autopsy findings	
<del>=</del>					perfor	med?		eble prior to pletion of cause ath?	
Completed					100	0171	- 1176		
					1 U Y		101	Yes 2□ No	
25. Wes case referred to medical examiner?	26. Place of Death (Check only one)  Hospitel: 1								
1 Yes 2 No	28e. Dete of Injury	2 ER/Outpe	tient 3LI DOA	4 Li Nursing F	dome 5 ☐ Reside				
27. Manner of Deeth  1 Inteturel 5 Pending Investigeti  2 Accident Investigeti  3 Sulcide 6 Could not determine	on (Month, Dey Ye	28b. Time of North							
4 Homicide determine		Specify)	street, factory, office	ð	City or Tow		or or nurer h	iodia ivuiliber,	
29a. Certifier 1 Certifying P	hyaiclan: To the best of m miner: On the basis of exe end menner steted	eminetion end/or	eeth occurred et the investigetion, in my	time, dete and plece opinion, deeth occu	e, and due to the curred of the time, d	euse(s) and ma lete end piece,	anner as stat and due to th	ed. he cause(s)	
29b. Signature end fittle of certifier	0		29c. Lice	nse number	2	29d. Date signe	d (Month, De	ay, Year)	
16	1/1 /	1101	A D	10587		6/22	1/99		
30. Neme and eddress of person who	complete cause of doubt	(Item 23e) /Tu	ne Print)	703 4 7	FRED	1565	rtest		
GEONGE 1. Chill V		CE - ! LEJ	1	AFFAIR	· Gacas	RICK A	()	1701	
31. Dete filed (Month, Day, Year)	32. Registrer's		1 TOKAL	MINING	1 1/1505	reser !		. 70.	

State

Registrar

JUN 2 4 1999



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

				Certif	icate of	f Death		Reg. No	0.		
1	1. Decedent's Name (First, Middle, L						2. Data of De Month	eath De	ay	Yeer	3. Time of De
	James Edward	-	4			1 02 Tour	June	13		1999	1112
4	4a Fecility Name (If not Institution, g		tal				or Location of Deat TS TOWN	h 40	c. County Was	of Death	ton
1	Washington Co		je (In yrs. lest bii	irthdey) If	f Under 1 Yaa	ar If Undar 24 H		rth			place (State or F
1		1□M 2□F		Yrs. M	lonths Day			8 Y99	330		Gland
1	Usual Residence of Decedent										011
1	10e. Stete 10b. County	+0:0	10c. City, Tow		ion Igersto	arriva				1	1 ☐ Yes 2
-	Md. Washir	igron						100 C	Hinan of V	Phot Cour	
	10e. Street and Number 10711 Crystal	Falls Dr.		- 1	10f. Zip Code	21742		10g. Ci	U.S	What Coun	itry 7
-	11. Marital Status	12. Was Decedant	Ever in U.S.	13. Was	Decedant of	Hisnanic Origin?	(Specify Yes or N	0-		e - Americ	en Indian,
	1 Never Marriad 2 Married	Armed Forces?				f Hispanic Origin? uban, Mexican, Pu	erto Rican, etc.)			ck, White,	
	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yaar or Dates:		10	Yas 2 N	lo Specify:			Specify	wh	ite
1	15. Decedent's I	Education	16a	1. Decedent	t's Usual Occ	supation	undkina	16b. F	Kind of Bu	usiness/inc	dustry
-	Elementary/Secondary (0-12)	College (1-4or 5	5+)			ne during most of w ired)	Olkany	Air	-0401	st Co	
-	12			Leau	d Man	40 Matheda N	lame (First, Middle				•
	17. Father's Neme (First, Middle, Les						iama (First, Middle Pearl Shr		n Sumem	10)	
$\vdash$	Elwood Ginevar		10	L Mailing A	Adress (Stra	eet end Number or			or Town	State 7in	Codel
	Wilma L. Gineva					al Falls					
1	20a. Method of Disposition	in (waye)	20h Place 0	of Dispositio			Date			City or To	
	Signature of runeral Service Library  23a Part1. Enter tha disaasa, or co shock, or heart failure. List only	2. No	tivio	22. Ne	ama and Add	tory June dress of Facility neral Hon	ne 12525 Smiths	Brac	dbwrg	y Ave	7 8 3  Approximate Interval Between
	1. Signature of Juneral Seprice Lice	mplications that causac y one cause on each lii	d tha death. Do	22. Na Dav p not enter th	ama and Add  vis Fun  the mode of d	tory June dress of Facility neral Hon	ne 12525 Smiths	Brac	dbwrg	y Ave 217	Approximate Interval Betwee Onset and De
	23a. Part1. Enter tha disaasa, or co shock, or heart failure. List onl	mplications that causar ly one cause on each li	d tha death. Do	22. Ne Dav	the mode of d  CEA  noe of):	tory June dress of Facility neral Hon	ne 12525 Smiths	Brac	dbwrg	y Ave 217	83
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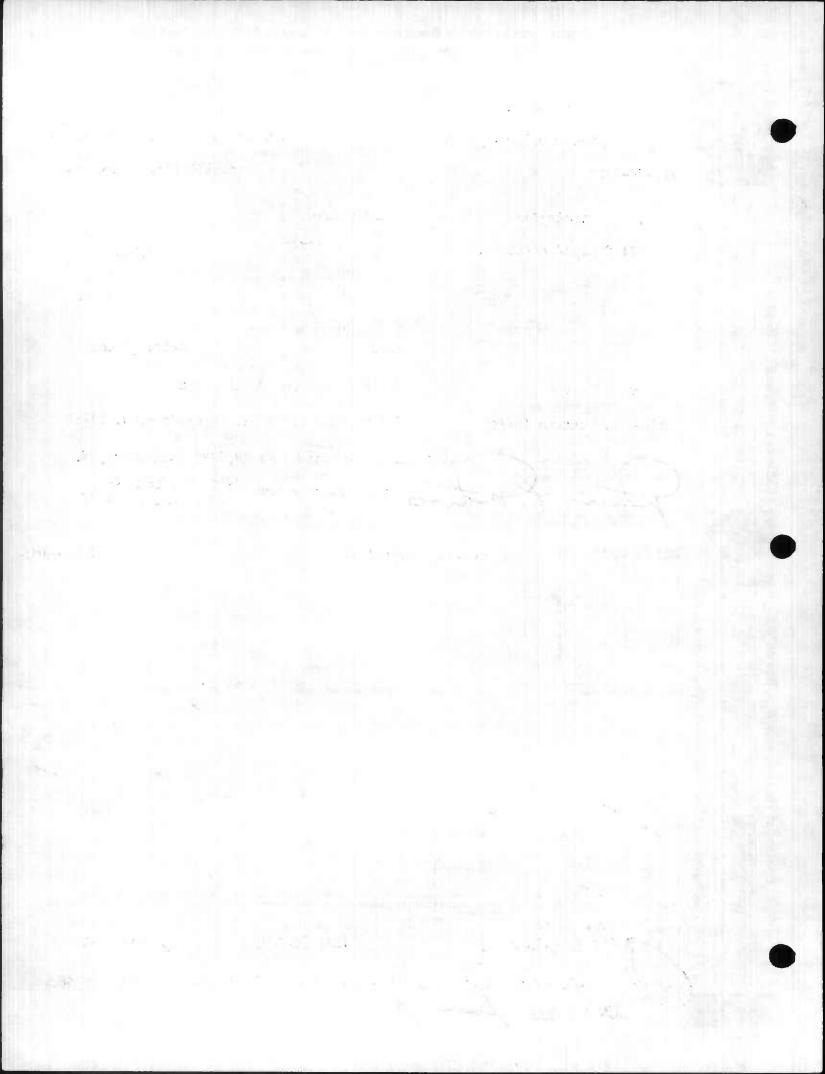
JOHN. P. REED M.D. 2291/ Jefferson BLVD SMITHS BURG MD 21783

31. Days filed (Month, Dey, Year)

JUN 17 1999

32. Figistra's Signature

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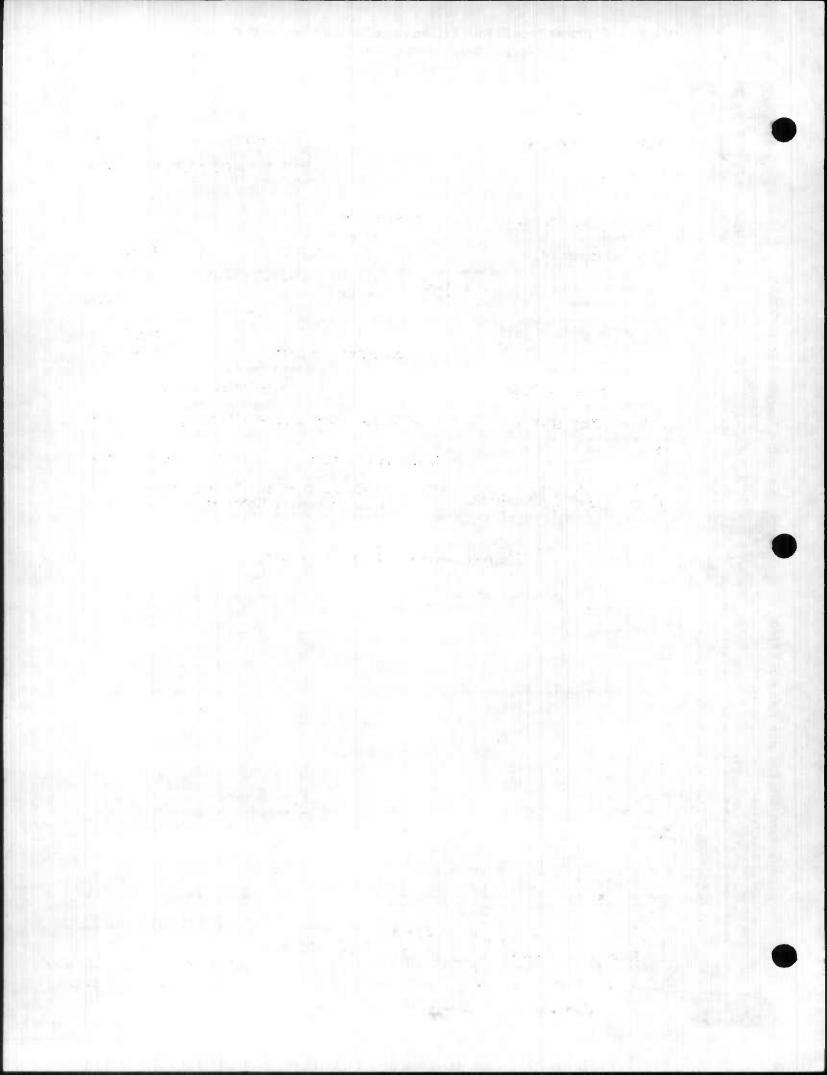


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State of Maryland / Department of Health and Mental Hygiene (

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, 2. Dete of Deeth Month **Physician** 0940 ROGER GRAY JUNE 1999 DALE /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Middletown Frederick 4306 Feldspar Rd. If Under 1 Year | if Under 24 Hrs. 8. Date of Birth Apr. 12, 1948 5. Sociel Security Number . Sex 1 M 2 □ F 7. Age (In yrs. lest birthdey) 9. Birthplace (State or Foreign **Funeral** Days Hours OKTA. 51 Yrs. 449-76-6992 **Director** Usual Residence of Decedent permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mentel Hyglena. Important: If Itam 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Mad call East has prust by not any other traumatic event, the Mad call East has prust by not other traumatic event, the Mad call East has prust by not other traumatic event, the Mad call East has prust by not other traumatic event, the Mad call East has prust by not other traumatic event, the Mad call East has prust by not other traumatic event, the Mad call East has prust by the Mad call East has been provided to the Mad call the 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director Middletown Frederick 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21769 4306 Feldspar Rd. Funeral 12. Was Decedent Ever In U.S. Armed Forces? 1 ≥ Yes 2 □ No 1968-If Yes, Give Year or Dates: 1988 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Maritel Stetus 1 Never Married 2K Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) federal Elementery/Secondery (0-12) College (1-4or 5+) government computer analyst 18. Mother's Name (First, Middle, Malden Sumeme) 17. Father's Neme (First, Middle, Last) Gladys L. White Frankie H. Gray 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) 4306 Feldspar Rd., Middletown, MD. 21769 L. Susan Gray (Wife) 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, State 1 DeBuriel 2 Cremetion 3 Removel from State 6/18 Okewah, Okla. Highlands Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licental 22. Name end Address of Facility Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD.

11 Ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, are on each line. 21769 Approximete Intervel Between Onsef and Deeth **Physiclan** /Medical Immediate Cause (Final 2 GEARS disease or condition resulting in death) Cisoma Examiner Due to (or as a consequence of) Examiner The law requires that the death cartificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of) 88 USB ō signed by the a Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? should Completed 24e. Wes en eutopsy performed? cartificata hes t 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director, Be 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 21 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funaral 28a. Date of Injury (Month, Dey Year) Certification: 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury af Work? 5 Pending Investigation 1 Natural death. 1 Yes 2 No 2 Accident ofter death Director: 6 ☐ Could not be 3 Suicide To the Hospital or Atte within 24 hours efter de To the Funeral Directo complately filled in by th 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) UTHA 1058 FREDERICA HOSP MEMORIA -30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print) VICE-1881. 1. ShITH FLEDELICE GEORGE 0 31. Date filed (Month, Dey, Year) 32. Registrars Signature State 1999 Registrar

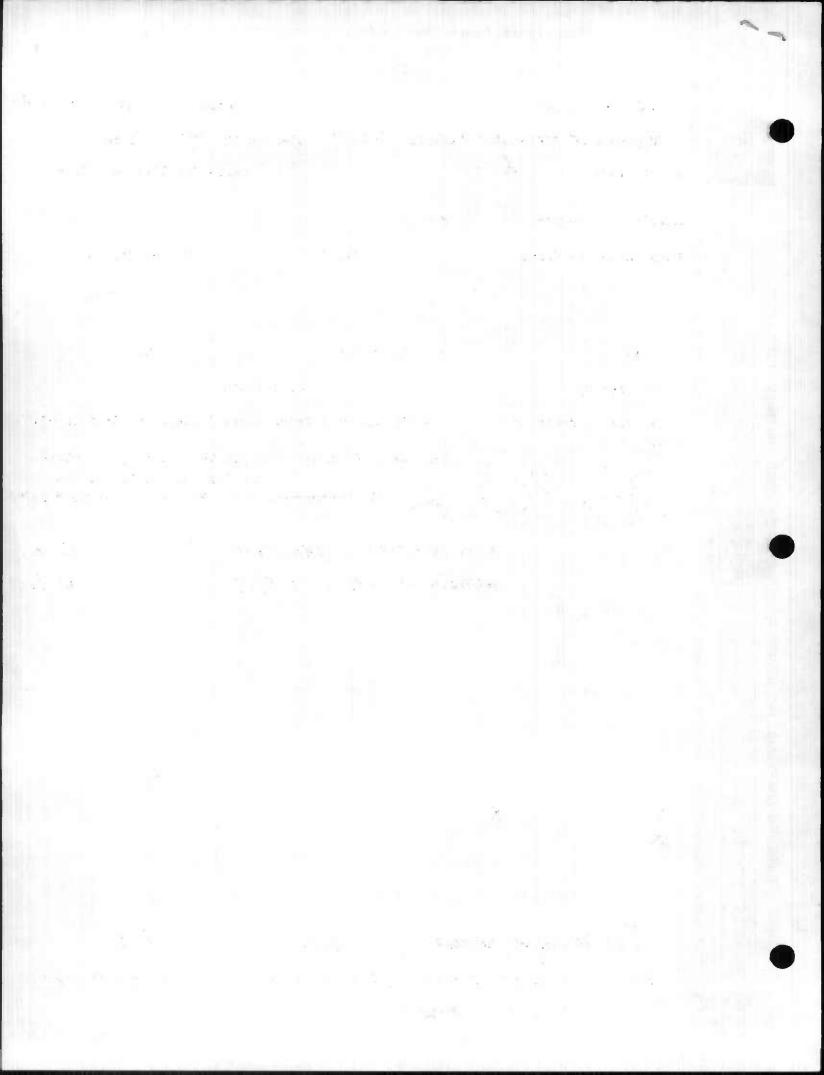


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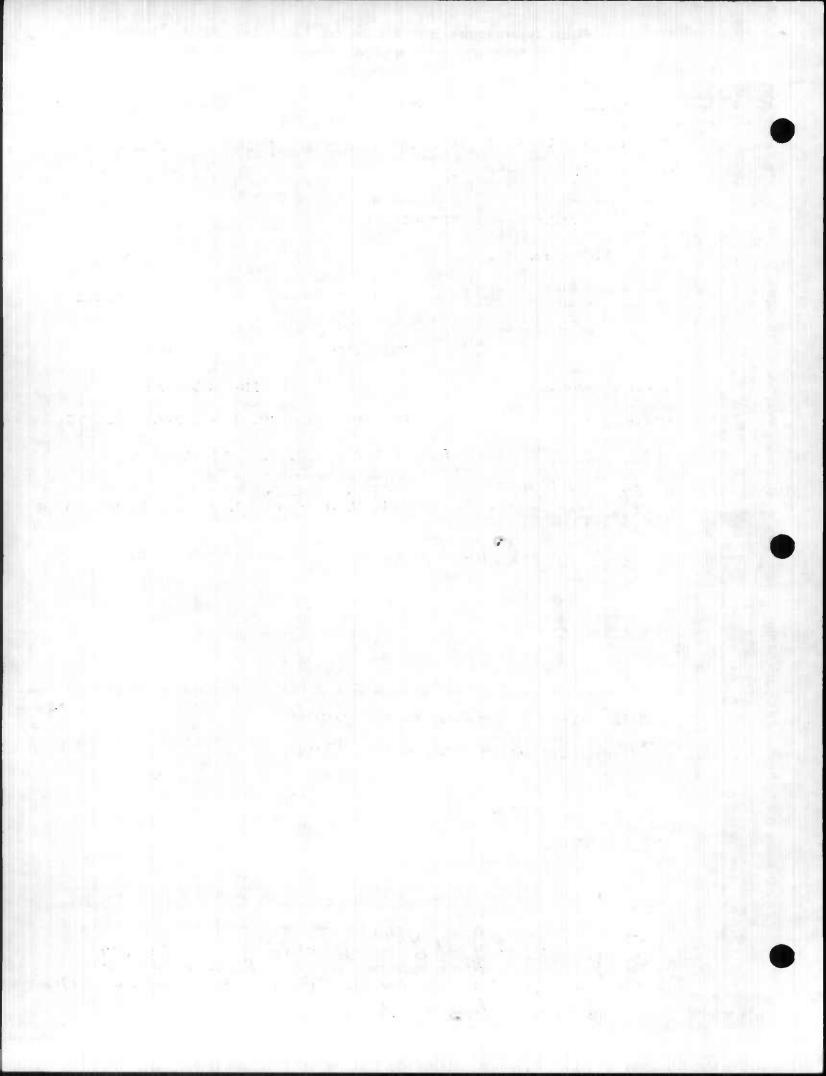
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State Registrar



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					Cei	rtificate of	Death		Re	g. No.			
	_	1. Decedent's Nama (First, Middla	, Last)						2. Date of Death		Veer	3. Tima of Death	
Physician		Frances			Gray				June 1	11, 199	Year 9	3:24 pm	
/Medica Examine		4a Facility Name (If not institution	, give street and numb	oer)			4b. City, To	wn, or Lo	cation of Death	4c. County	of Death		
		FREDERICK	MEMORIAL	HOS	PITAL		FREI	DERI	CK	ानप्रम	DERIC	אר	
Funeral Director		5. Social Security Number 213-14-2974	6. Sex 7		last birthday) Yrs.	Months Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day, APR. 9			ace (State or Foraig ry)	
		Usual Residence of Decedent											
how I	111	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation					10	d. Inside City Limits	
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3a or 28	5	10e. Street and Number 3434 BIG WO	DODS RD.			10f. Zip Code	754		10	What Count			
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permit. Pages I Department of I Important: If its any Injury or of 20026.		21. Signature of Funeral Sarvice I	icensee		G	ARY L.	POTT	TNC	FUNERA	L HOME	E	Approximate	
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been	Completed	CHRONIC O	BSTRUCT, 43	- Pu	Lh. NA	ir) D	SEAK		24a. Was a perform	n autopsy med?	ava	ere autopsy findings allable prior to mpletion of cause death?	
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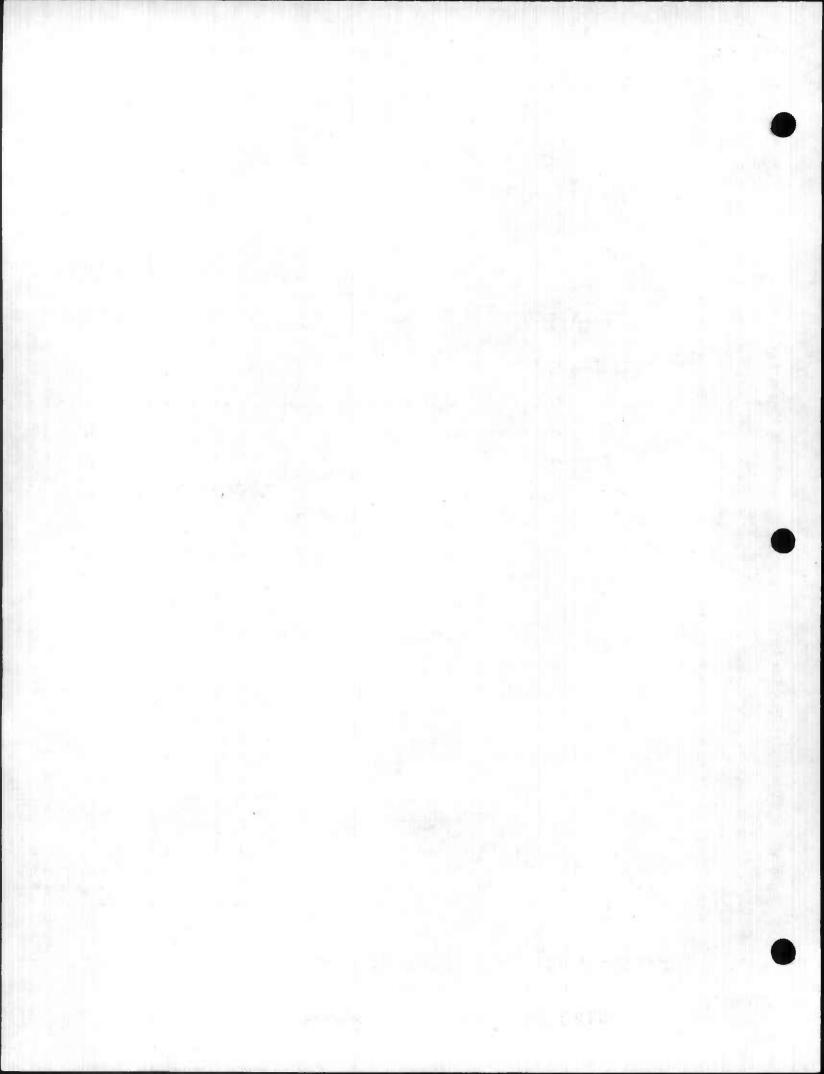
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Dir.	10a. Street end Number 4711 Maple Grove	Road		10f. Zip Code	21074		10g. Citizen of What Country? USA						
72 hours after death with the Maryland "natural", or flema 23a or 28a-f ahow notes! Examiner must be notified at leted by Funeral Director	11. Meritel Stetus	12. Wes Decedent Eve	arin IIS   13	Was Decedent of	Hispanic Origin? (S	nacify Vas or No-		e - America	n Indian				
Her d	Never Merried 2 Married	Armed Forces?	ST WT O,O. 10.	if Yes, specify Cul	oan, Mexican, Puert	Rican, etc.)		ck, White, e					
ar, or	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Dates:		1□ Yes 2□XNo	Specify:		Specify	· Wh	ite				
"natural", edical Ex- leted by	15. Decedent's Ed		16a. Dece	edent's Usual Occu	pation		16b. Kind of Br	usiness/Inde	ustry				
ed within 72 ho ygiene. her than "natur it, the Wedeal Completed	(Specify only highest gre Elementery/Secondery (0-12)	completed) College (1-4or 5+)	(Give	e kind of work done DO NOT use retin	during most of world)	king							
d with	12	Oolloge (1-401 34)	Tool	and Die	Maker		Fairl	awn					
tal Hy d other	17. Fether's Neme (First, Middle, Last)	)			18. Mother's Nan	ne (First, Middle, I	Maiden Suman	16)					
Wentud b	Steven Kent Hare	9			Bever.	ly Lee B	arrett						
and land	19e. Informent's Neme/Reletionship (				t and Number or Ru								
and and all all all all all all all all all al	Steven Hare, Sr,	tather	Grove Rd,	Hampste	ad, MD	21074							
of He of He r oth	20e. Method of Disposition	Removel from State	Date	20c. Location -	City or Tov	vn, State							
permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If itam 27 ia marked other than "nat any Injury or other traumatic avant, the Medicande.  To Be Complete	1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify)  Cemetery, cremetory or other place)  Hampstead Cemetery  6/21  Hampstead												
Departi Departi Importi any Inji	21. Signature of Fuperal Service Licen	1500, 7 (2)	ess of Fecility	Eline Fu	neral H	ome							
82 5 8	Steves Cicco 934 South Main St, Hampstead, MD 21074  23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,  Approximate												
w requires that the death certificata be assocuted been signed by the attending physician and should be detached for use as the bunal-transit leted by Physician/Medical Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):    Due to (or as a consequence of):												
death certifies attending and for use a storian/Me	Part II. Other algorificant conditions or	dontributing to death but n	not resulting in the	underlying cause g	iven in Part I.	23b. Did to	tobacco use contribute to the cause of			eath			
that the dea ed by the at detached for						1 U Y	es 22 No	3 Prob	ebly 4□Unk	inow			
law requires that tas been signed b 2 should be deten						24a. Wes a		24b. We	re autopsy findir	ngs			
The law requir						INSPE		CON	ilable prior to apletion of cause eath?	e			
The language 2						1 TNSFE			Yes 2□ No				
ifficat or, p	25. Was case referred to medical				26 Place of Date	th (Check only or		1 ,0	163 20140				
Physician: this certific inal director, TO Be	examiner? XXYes 2 No	Hospitel:	2 ER/Outpatie	ent 3 DOA O	ther	ome 5)()(Reside		er (Specify	)				
g Phy er this neral c	27. Manner of Death	28a. Date of Injury (Month, Dey Y	28b. Time			28d. Describe h				-			
tal or Attanding P rs after death. al Director: After ted in by the funer ed in by the funer Certification:	1 ☐ Neturel 5 ☐ Pending investigation			10 45	Yes 2 No	Subje	ct sh	of .	self				
or Attandi after death. Director: A d in by the fi	3 Suicide 6 Could not be determined	288. Pieca of injury	- At home, ferm, s		ri e	28f. Location (S	treet and Numb	per or Rural	Route Number,	,0			
S aft of in Cert	38 Suicide 4 Homicide  6 Could not be determined  28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)  Shed at 1851 dence  28l. Location (Street and Number or Rural Route Number of Bural Route Number of The Street and Number of Rural Route Number of The Street and Number of Rural Route Number of The Street and Number of Rural Route Number of The Street and Number of Rural Route Nu												
To the Hospital or Attanding Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2  Medical Certification: To Be Comp		ysician: To the best of miner: On the basis of exent menner steted	ny knowledge, dee aminetion and/or in	th occurred et the t			ause(s) and mi	anner as sta	ated.				
vithin forth	29b. Signature and title of certifier	9d. Date signe	d (Month, E	Day, Year)									
- > - 0	Atala	2 4/101	15	OCM	Ξ		JUNE 1	8, 19	99				
	30. Neme end address of person who	completed cause of deat	h (Item 23a) (type	Print)									
		adentz,			Baltimor	e. Marvl	and 212	01					
	31. Date filed (Month, Day, Year)	32. Registrer's				-,,			-				

State

Registrar

JUN 2 1 1999



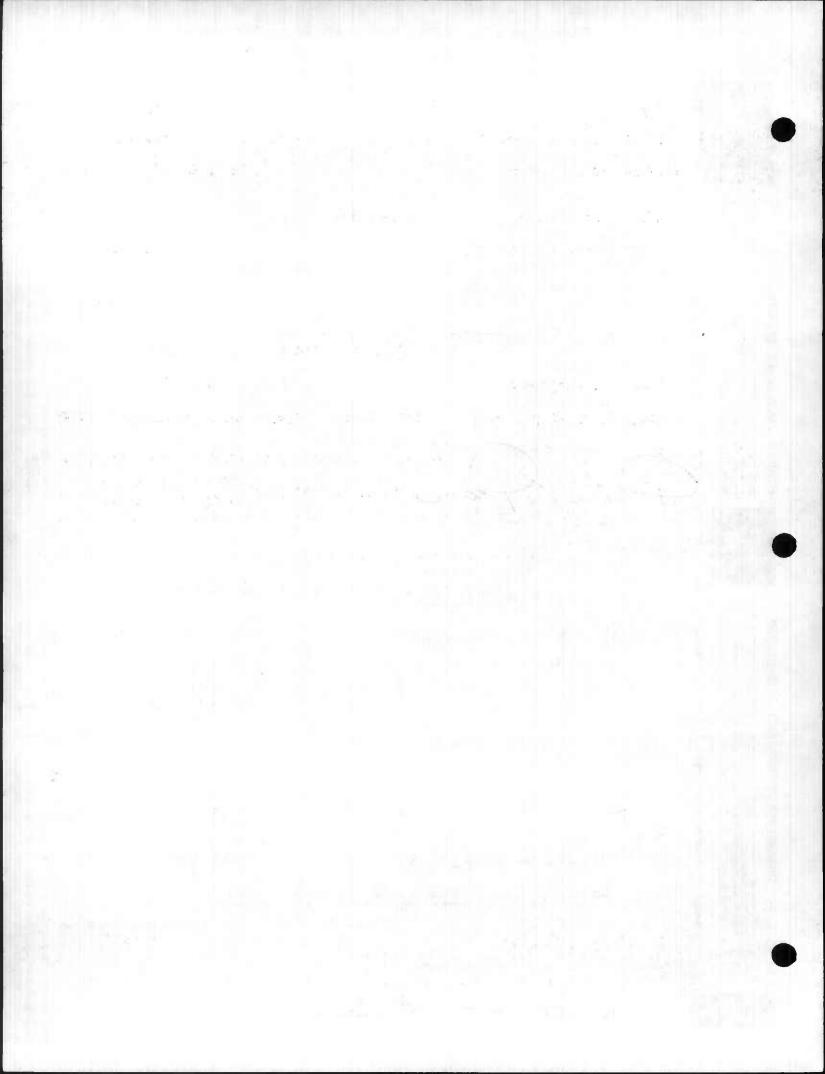
### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician** Horst Cynthia Louise June 8:50 1.4 171999 /Medical 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner 12706 Little Antietam Rd. Washington Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Deys Hours Min. Sept. 26, 1952 5. Sociel Security Number 7. Age (In yrs. lest birthday) 9. Birthplece (State or Foreign **Funeral** 1□M 20F Maryland 217-56-0988 46 Yrs. Director Usual Residence of Decedent 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits The Maryla 1 ☐ Yes 2X No Md. Washington Hagerstown Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? than "natural", or items 23s or the Medical Examiner must be r 21742 U.S.A. 12706 Little Antietam Rd. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Bleck, White, etc. permit. Pages 1 and 2 should be liked within 72 hours sher Docarment of Health and Mercal Hybines. Introductarit. It lisen 37 is merced offer than "neturals, or the any injury or other traumetic event, the Medical Examine 1 ☐ Never Married 2 🕅 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 18e. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Substitute Teacher School 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Mary E. Norwood Vinson T. Keefauver 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 12706 Little Antietam Rd. Hagerstown. Md. 21742 Delbert G. Horst (Husband) 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Slete 1 Burial 2 Cremetion 3 Remoration State
Donation 5 Other (Specify) June 28, 1999 Hagerstown, Md. Rose Hill Cemetery 22. Name end Address of Fecility 21. Signature of Funeral Service Licens 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting in deeth) Respiratory Failure
Due to (or es e consequence of): Examiner Lateral Sclerosis Physician/Medical Examiner 4415. lew requires that the death certificate be executed physician end s the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) ettending physigned by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 2500 3 Probably 4 Unknown by 24b. Were eutopsy findings eveileble prior to completion of cause of death? Completed 24e. Wes an autopsy performed? 2 No 1 ☐ Yes 2 No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: After 5 Pending Investigation Neturel 1 Yes 2 No 2 Accident after deet the Funeral Director filled in by the 6 Could not be determined 28e. Plece of Injury - At home, farm, street, tactory, offica building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 ☐ Homicide Hospital of Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signeture end title of certifier 29d. Dete signed (Month, Dey, Year) 29c. License number Mary E. Money is. 023815 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 354 MILL Mary E. Money HAGERSTOWN, UND STREET, 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State JUN 2 5 1999

Registrar

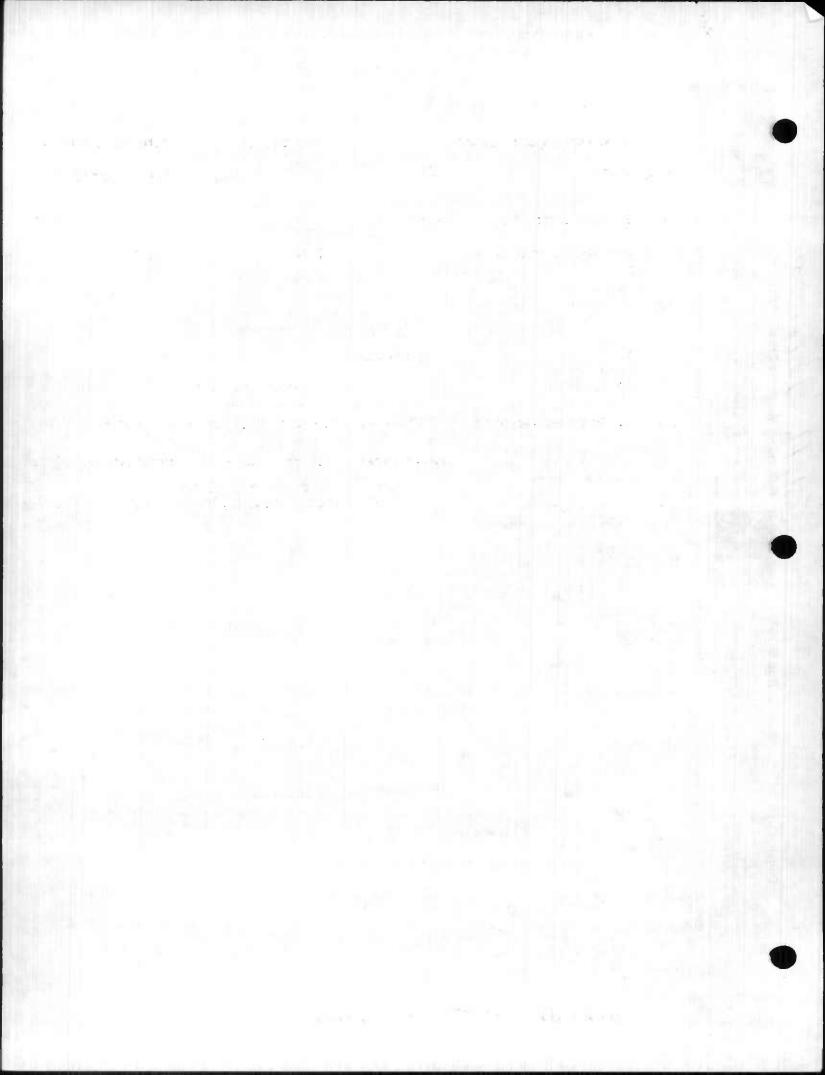
**DHMH 16 Rev 6/95** 



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	1. Decedant'a Nama (First, Middla, Li	ast)				2. Deta of De			3. Time of Death				
	EDITH COR	1667 1407	flik!	SON		Month	Day	Yaer 1999	10000				
4	a Facility Name (If not institution, gi				4b. City, Town,	or Location of Deat	h 4c. County	of Death					
	17307 West Washi			st hirthday) If Undar 1 Y	Hagerst				County				
		Sex 7. Ag 1 □ M 2 1 F	ge (in yrs. las 8			in. (Month, De	y, Year) 29, 1914		placa (Stata or Fore htty) ryland				
-	Usual Rasidance of Decedent					000, 2	2, 1214						
	10a. Stete 10b. County	t		Town or Location				1	0d. Inside City Limi				
		gton Co.	Hag	erstown 10f. Zip Coo	4-		10g. Citizen of	Affron Cour					
	10e. Street and Number 17307 West Washir	aton Stree	et	10t. 2ip Coo	21740		US.		my :				
_	11. Maritai Status	12. Was Decadant	Ever in U,S.	13. Was Decedant	of Hispanic Origin? Cuban, Maxican, Pu	(Specify Yas or No		ca - Amaric					
	1 Nevar Married 2 Married	Armed Forcas			No <i>Specify:</i>	arto Hican, etc.)	Specif	ck, Whita,	ite				
	3 Widowed 4 □ Divorced	Year or Datas:						*****					
_	15. Dacedant's E (Specify only highast gr			16a. Decedant's Usual Oc (Giva kind of work do lifa. DO NOT usa re	ccupation ona during most of etired)	working	16b. Kind of B	usiness/in	dustry				
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	17. Fathar's Name (First, Middla, Las				18. Mother's I	lama (First, Middla	, Meiden Sumai	me)					
	Charles E. Smit	h			Bessi	e U. Bak	er						
	19e. Informant's Name/Ralationship			19b. Mailing Addrass (St									
	Joyce C. Shumaker/Daughter 17307 W. Washington St., Hagerstown, Maryland 217  20b. Piece of Disposition (Nama of D												
	1 SpBurial 2 Cramation 3 Ramovel from Stata camatary, crematory or other place)												
	shock or heart feilure. List only	nplications that cause	d the daath.	Do not antar tha moda of	stern Blvd dying, such as can	d., N., Hag	erstown arrast,	, Mary	Approximate				
	shock, or heart feilure. List only Immediate Ceuse (Final disease or condition resulting in deeth)	. CARI	010-	RESPIRATO	dying, such as can	fiac or raspiratory a	erstown arrast,	Mary	1and 2174 Approximate Interval Batween Onset and Daath				
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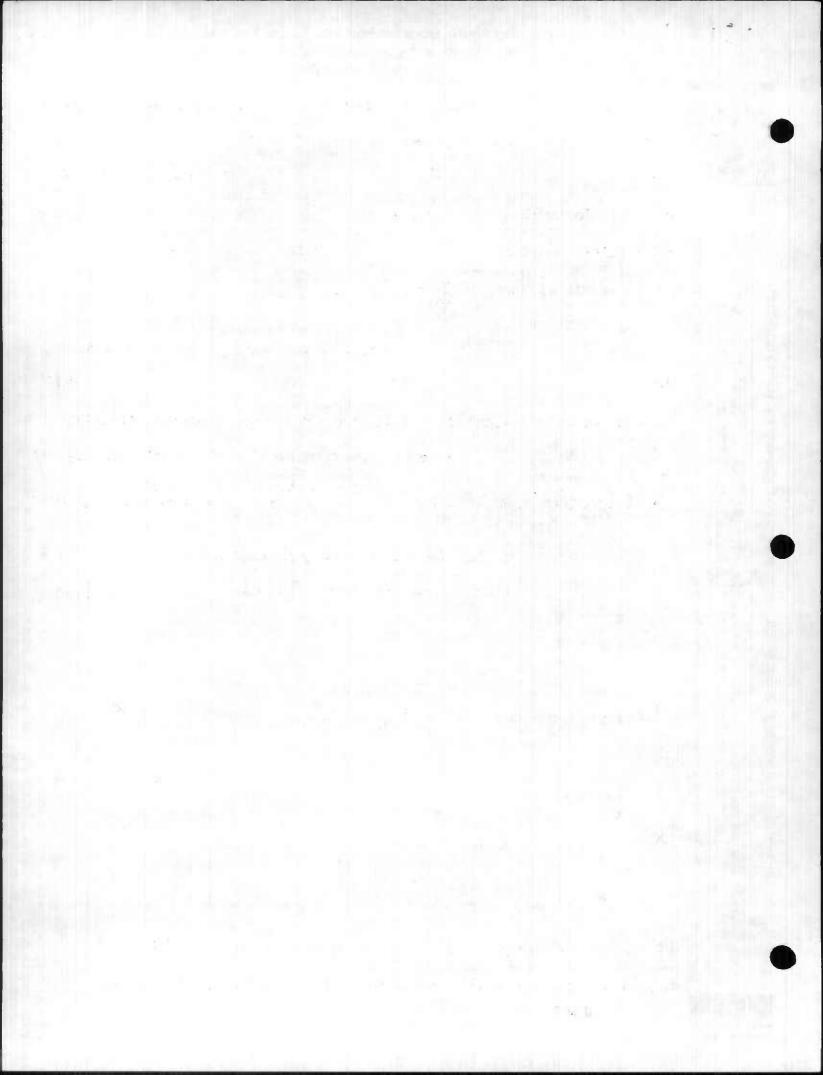
State Registrar



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	Decedent's Nama (First, Middla, La	etl	(	Certificate of L	Death	2. Date of Dea	leg. No.		3. Time of Death	
ysician Medical	MORRIS	DONALD		HEWITT		Month	8, Dey 1999	Year 8	3:42 AM	
ner	4a Facility Name (If not institution, give				b. City, Town, or L		4c. County	of Death		
	Frederick Me 5. Social Security Number 6. S	Sex 7. Age (In yr.		day) If Under 1 Yaar	Freder			rede:	C1 CK	_
	578-20-3729 Usual Residence of Decedent	ØM 2□ F	74 Y	Months Days	Hours Min.	8. Date of Birth (Month, Day Jan 20,	1925	Mar	yland	
tor	10a. State 10b. County Maryland Freder			or Location derick	76			100	d. Inside City Limits	
al Director	10e. Street and Number 10214 Little Roc	k Lane	П	10f. Zip Code	1702		U.S.A		y?	-
by runeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	H Vac Civa	u,s. 943– 945	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐XNo	ispanic Origin? (Si n, Mexican, Puerto Specify:	pecify Yas or No- Rican, atc.)	14. Race Blac Specify	k, White, et	c.	
Completed	15. Decedent's E (Specify only highast gra Etementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)		Decedent's Usual Occupi Give kind of work done of life. DO NOT use retired			16b. Kind of Bu			
50	7 17. Father's Neme (First, Middle, Last	)	INC	rsery & Flo	18. Mother's Nem				28	
10 Be	Alonzo		Н	EWITT	Susie				RICE	
	19e. Informent's Name/Reletionship (			Meiling Address (Street a						
	Mrs. Maetta Brow		Place of I	0214 Little Disposition (Name of		Date Date	20c. Location			
	1 Buriel 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif			own Cemeter		, 1999			laryland	
	Signatury of Funeral Servica Lice     Servica Lice	Berew MOC	)706 ath. Do no	106 East (	& Bastoro Church St	. Frede	rick, M	aryla	nd 21701 Approximate Interval Between Onsat and Death	
	Immediate Cause (Finel disaasa or condition resulting in death)	a. Sudden Oue to	Card (or as a co	iar Death insequence of): Arteri	1Arry	thmi	~	-	lhr	
/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to	(or es a co	Arteronsequence of):	Vise	ase			lmo	
SICIAL	Part It. Other significant conditions of	ontributing to death but not re	esulting in	the underlying cause give	en in Part I.	23b. Dld t	obacco usa cor	tribute to t	the cause of death?	
by Physician/M	Recent Co			^		101	/es 2□ No	3 Probe	ably 4 Unknown	
Completed							en autopsy med?	avail	e autopsy findings labla prior to pletion of cause eath?	
E O						101	es 2 No	10	Yes 3 No	
Be	25. Was case referred to medical axaminer?	Hospitel:	4 .	Oth	26. Place of Dea	th (Check only o	ne)			_
tlon: To	1 Yes 2 No  27. Manner of Death  1 Naturet 5 Pending investigatio	28a. Date of Injury (Month, Dey Year)	28b. Ti	me of 28c. Injury	4 ☐ Nursing H	ome 5 Resid	lence 6 □Othe now injury occurr			-
Certification:	3 Suicide 6 Could not be determined	e Ope Place of Injury At	home, fam	n, street, factory, office		28f. Location (S City or Tox	Street and Numb	er or Rurel	Route Number,	
edical C	29e. Certifier (Check only one)	ysician: To the best of my kininar: On the basis of examinant and manner stated.	nowledge, nation and	death occurred at the tim for investigation, in my of	ne, dete and place pinion, death occu	and due to the cred at the time,	cause(s) and me dete end place, a	nner es sta and due to t	ited. the cause(s)	
Me	29b. Signature and title of cartifles	Los ind		29c. Licans	a number 5047 3	197	29d. Data signed	1 (Month, D.	ay, Year)	
	30. Name and address of person who Michael W. Leva	· ·		ype, Print) v.a+L 5+	Fred	lervick.	mD 2	1701		
State strar	31. Date filed (Month, Day, Year)	32. Registrar's Sig		B. 1	2011	1				

DHMH 16 Rav 6/95



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State of Maryland / Department of Health and Mental Hygiene > Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month JUNE **Physician GEORGE** WAYNE HAWES 16, 1999 7:10 PM /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner Frederick Memorial Hospital Frederick Frederick B. Date of Birth Month, Pay, 1948 Mary Land

8. Date of Birth Mary Land

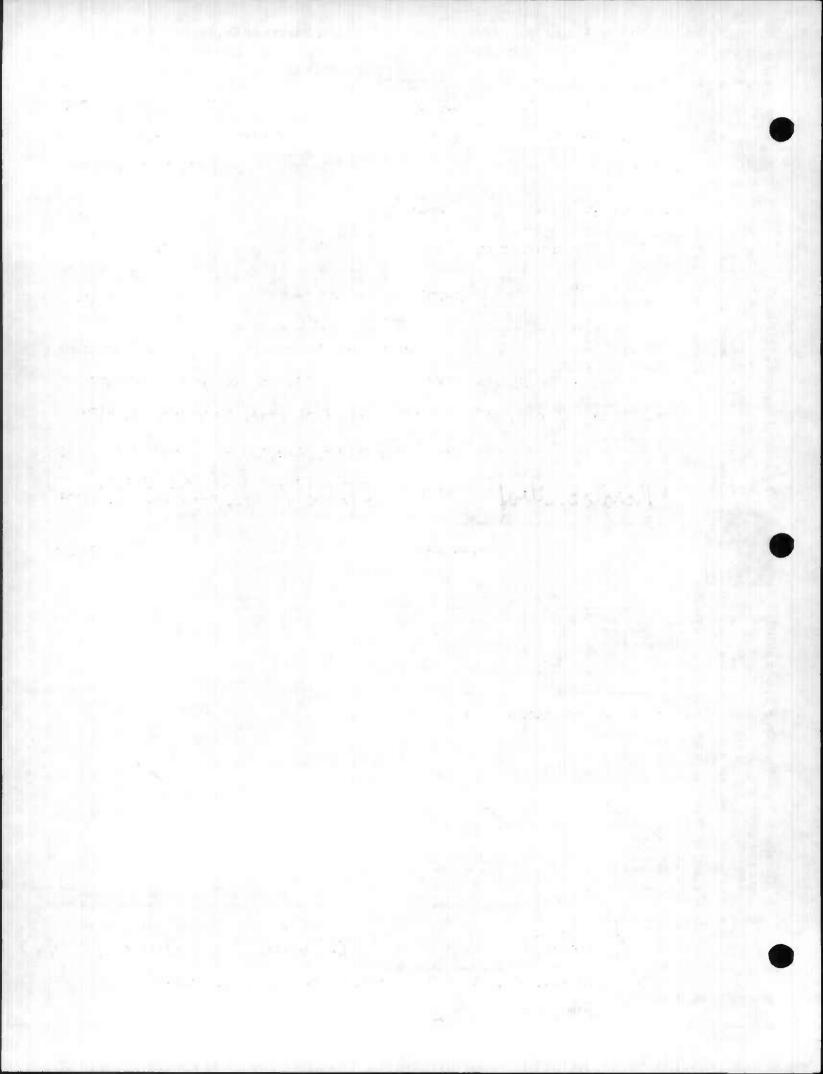
9. Birthplace (State or Foreign Mary Land) 5. Social Security Number 214-48-4508 7. Age (In yrs. lest birthdey) 50 Yrs. If Under 1 Year **Funeral** 10€M 2□ F Months Days Hours Min. Director Usuai Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23s or 25s-4 show any injury or other traumatic avent, in Medical Examine must be not item and once. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. Count Maryland Frederick Frederick Yes 2 No Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 807 F Stratford Drive 21701 U.S.A. Funeral 12. Was Decedent Ever in U,S. Amed Forces? MAYes 2 □ No. If Yes, Give 1009—1974 Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) Coilege (1-4or 5+) Maintenance Department City Government 18. Mother's Name (First, Middle, Melden Sumame) 17. Father's Name (First, Middle, Last) George Washington HAWES Helen Marguerite SCHULTZ 19a. Informant's Name/Relationship (Type, Print)
Mrs. Ginger L. Hawes, wife 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 807 F Stratford Drive, Frederick, Md. 21701 20b. Place of Disposition (Name of cemetery, grametory or other place)
Mount Olivet Cemetery, June 19, 1999 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20c. Location - City or Town, State Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) <sup>22</sup>, Name and Address of Facility Keeney and Basford P.A. Funeral Home 21. Signature of Funeral Service Licent M00255 106 East Church St., Frederick, Md. 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervai Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical pneumonia 1 day Examiner Due to (or as a consequence of): Examin the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury g physician and as the bunal-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): for use as by the a 23b. Did tobecco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 2 The law requires that head and neck cancer d bengis þ 24b. Were autopsy findings aveilable prior to completion of cause of death? been sign 24a. Was an autopsy performed? Completed has. irector, page 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: 24 hours after death. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home P 1 Yes 2 ER/Outpatient 3 DOA Inpatient 5 Residence 8 Other (Specify) this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident Director: / 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end manner es stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier edical 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie 30. Name any address of person who completed cause of death (Item 23a) (Type, Print) Allen J. Gilson, M.D., 1475 Taney Avenue, Frederick, MD.

32. Registran Signature

18

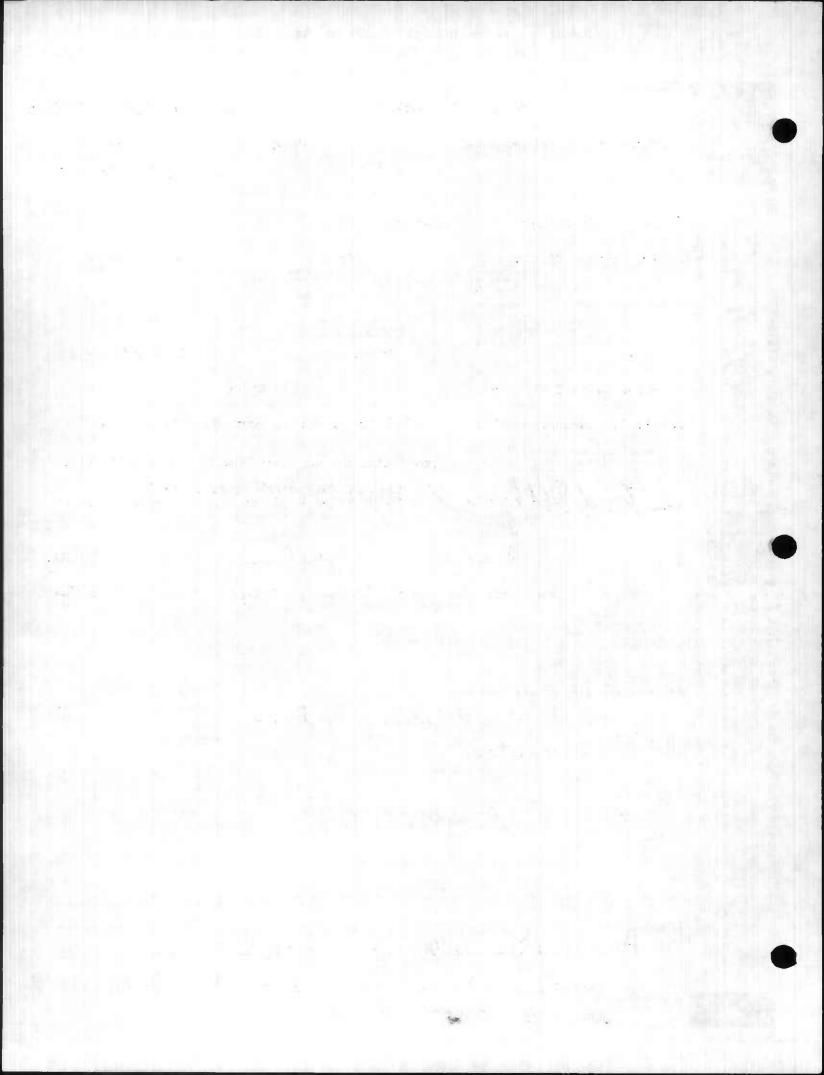
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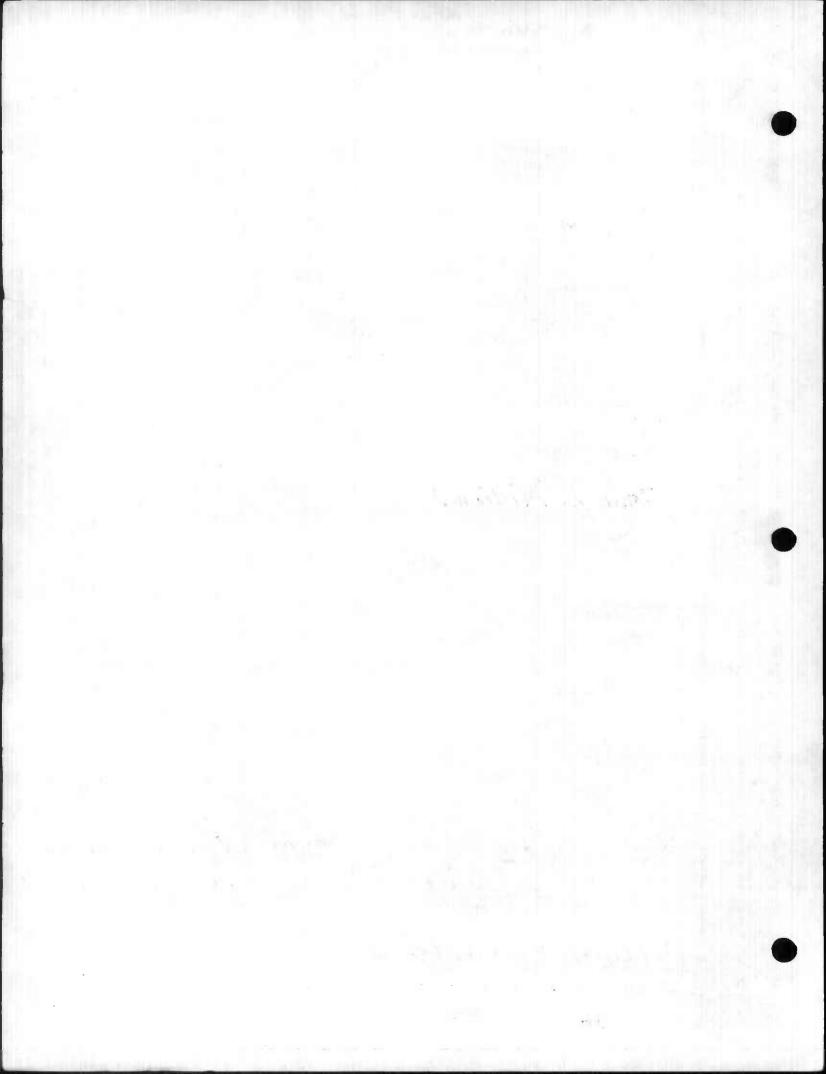
				Cer	tificate of	Death		Reg. No.			
Physician	Decedent's Name (First, Middle		N DAY				2. Dete of D Month	eath Day	Year	3. Time of Death	
/Medical		Wayne	Elder 1	Hawki			June		999	10:00pm	
Examiner	4a Facility Name (If not institution	, give street and numi	ber)			4b. City, Town, o	r Location of Dea	th 4c. County	of Death		
	Montgomery Gen	eral Hospi	tal			Olney		Mo	ntgom		
Funeral	5. Social Security Number	6. Sex 7	. Age (In yrs. las		If Under 1 Year Months Deys	If Under 24 H	n. 8. Date of B	irth lay, Year)	9. Birthpl Count	ace (State or Foreign	
Director .	213-56-3610	TEM ZUF	51	Yrs.			Feb.	15,1948	Ma	ryland	
,	Usual Residence of Decedent		10- 00- 7						140	hal de alieta Olde d'Imple	
the Medical Example must be northed at ompleted by Funeral Director	10a, State 10b, County		10c. City, T	own or Lo	cation				10	od. Inside City Limits  1X Yes 2 □ No	
ct	Maryland Fred	erick	Fred	erick						TALITES ZLING	
Director	10e. Street and Number				10f. Zip Code			10g. Citizen of 1	What Count	iny?	
al	5802 G Lantana	Circle			21703			United	Stat	es	
Funeral	11. Meritel Status	12. Wes Deced	ent Ever in U,S.	13. V	Was Decedent of H	lispanic Origin?	(Specify Yes or N	0- 14. Rec	ce - America		
	1 Never Married 2 ☐ Marri	ed 1 ☐ Yes 2	IX No		1 ☐ Yes 2 ☒ No	Specify:	orto ritoari, oto.,			NG.	
ò	3 Widowed 4 Divorced	If Yes, Give Year or Dat			THES ZEATHO	эрөспу.		Specify	Wh	ite	
3	15. Decedent	's Educetion		6a. Deced	dent's Usual Occup	ation	orkina	16b. Kind of B	usiness/Ind	lustry	
Completed	(Specify only highes Elementary/Secondary (0-12)	Coilege (1-4	lor 5+1	life. L	DO NOT use retired	d)	rorking				
	12	College (1-	101 0+)	A	ssembler			MIG Wel	ding	Guns	
	17. Fether's Name (First, Middle, I	Last)				18. Mother's N	lame (First, Middl	e, <i>Maid</i> en <i>Sum</i> an	ne)		
	Sterling Lewis	Hawkins Sr	kins Sr.				Elder				
	19e. Informant's Name/Relationsh			19b. Mailin	ng Address (Street		ber, City or Town	State, Zip	Code)		
2	Donald L. Hawki				Timber					1770	
	20e. Method of Disposition	ns, broche	20b. Piac	e of Dispo	sition (Name of		Date	20c. Location			
	1 ☐ Buriai 2 ☑ Cremation		ate	-	natory or other ple						
	4 Donation 5 Other (Sp		Metr	_			Inc6/1/	Alexand	iria,	Virginia	
any injury once.	21. Signature of Funeral Service	2/1/	,				h P A	Funeral	Home		
	Olin L. Molesworth P. A. Funeral Home 26401 Ridge Road, Damascus, Maryland										
	23a. Part1. Enter the disease, or shock, or heart failure. List	complications that car	used the death.	Do not ent	er the mode of dyir	ng, such as card	lac or respiratory	arrest,		Approximate Interval Between	
	Side of the fall of the same	0								Onset end Death	
	Immediate Cause (Final disease or condition	Dan	Q		. 1.	2:0	. 0			dan	
	resulting in death)	a Kee	Piroto for a	3 1 U	number of	acce	CC .		- 11	aug	
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college	resulting in death) Last.		Dog to for a	a conseq	out out.						
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oy ruyanda	D- 4 11 O45 1 161 4 4 4141		ale le caline de la caline del	- I - Ab		in Boat	an ni	d tab	and of breaks Ass	the cause of death	
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	25. Wes case referred to medical exeminer?						Death (Check only	one)			
	1 Yes 25€No	Hospitei:	patient 2 EF	VOutpatier	nt 3 DOA Oth	ner: 4 🗆 Nursing	g Home 5□ Re	sidence 6 Oti	her (Specif	y)	
	27. Manner of Death	28a. Date of	Injury 21 Day Year)	Bb. Time of injury	f 28c. inju Wo	ry at rk?	28d. Describe	e how Injury occu	rred		
	2 Accident investig	39		,		Yes 2 □ No					
	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	ined 289. Place of	f Injury - At hom-	e, farm, str	reet, fectory, offica			(Street and Num own, State)	ber or Rura	I Route Number,	
	4 LJ Homicide	building	g, etc. (Specify)				Ony or r	Own, Otale)			
	29a. Certifier CertifyIn	g Physician: To the b Examiner: On the bas	est of my knowle	dge, death	h occurred at the ti	me, date end pie	ece, and due to th	e ceuse(s) end m	anner as s	tated.	
	(Check only 2 Medical I	Examiner: On the bas end menne	is of examination or stated.	and/or In	vestigation, In my	opinion, death or	ccurred at the time	e, date end piece,	, and due to	the ceuse(s)	
	29b. Signature and title of certifier				29c. Licens	se number		29d. Date sign	ed (Month,	Dey, Year)	
	men	0000	9004	T A .	10 N2	851	7	1.41	11	1909	
	30. Name and eddress of person	who completed source	of death /ltem 3	(Type	Print)	0 20	)	June	10,	(7)	
	7 41 11:	11 01.	Resea	.,	0/	2 1- 2	un Po	etarle	M	87.8AC	
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State of Maryland / Department of Health and Mental Hygiene 9 9 2 1 1 0 0

			Ce	ertificate of	Death		Reg. No.		
Physician	Decedent's Nama (First, Middle, La			N BE	W.	2. Date of D	Day	Year	3. Time of Death 0331 AM
/Medical Examiner	4a Facility Name (If not institution, giv					JUNE	ith 4c. County	of Death	
3)	PENN SHOP ROAD AT				MONRO			DERICK	
Funeral Director	216-60-8/59	ex 7. Age (N	n yrs. last birthday 43 Yrs.	Months Days	If Under 24 Hours	Min. (Month, L	irth Day, Year) 16,1955	9. Birthple Countr Mary	ice (State or Foreign y) 1and
ter death with the Maryland frems 23a or 28a-f show the mark be notified at	Usual Residence of Deceden1   10a. State   10b. County		Damascus					10	d. Inside City Limits
with the Ma or 28a-fa be notified	10e. Street and Number		Damascat	10f. Zip Code			10g. Citizen of		y?
era 23	26700 Howard Ch			208		0.40	U.S.		
urs af	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: 1		. Was Decedent of H If Yes, specify Cube 1 ☐ Yes 2 No	Ispanic Originan, Mexican, I	n? (Specify Yes or N Puarto Rican, etc.)		ck, White, e White	lc.
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d within piene.	Elementary/Secondary (0-12)	College (1-4or 5+)	IIIe.	DO NOT use retired	3)				
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d 2 should be flight and Mental Hy 7 is marked other traumatic avent	19a. Informant's Name/Relationship (		19b. Mai	ling Address (Street					Code)
5 = 7 E	Carol Hilton Lamb	ert - Siste	r 2670	0 Howard	Chape1	Drive, D	amascus,	Mary!	land 2087
permit. Pages 1 as Department of Hear Important: If Itam; any injury or othe ping.	20a. Method of Disposition  15. Burial 2 Cremation 3  4 Donalon 5 Other (Specification of Funeral Service Licental Service Li	Removal trom Stata	Howard (	Chapel Cen	netery ss of Fecility oleswor	th P.A.,	Funeral	orner, Home	
antificate be executed ling physician and se st the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b	e to (or as a conse	equence of):					
for un	Part II. Other significant conditions or	d.	22b Di	d tobacco use oc	untribute to	the cause of death			
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ysician: The secretificata director, pag	25. Was case referred to medicat examiner?	Manahat.		0.11		Death (Check only	one)		
T de DT	1\( \) Yes 2 \( \) No  27. Manner of Death  1 \( \) Naturat 5 \( \) Pending	Plospital: 1 Inpatient  28a. Date of Injury (Month, Day Ye	2 ER/Outpatie	of 28c. Injur Wor	y at k?		sidence 6 XXXIII how injury occur		ROADWAY
To the Hospital or Attanding P within 24 hours after death. To the Funeral Director. After completaly tilled in by the funeral Medical Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (S	At home, farm, s Specify)	>	Yes 2/2 No	28t. Location City or T	(Street and Numi own, State) Pe cicht Cou	ber or Rural	y auto Route Number, op Roac larylane
he Hospital in 24 hours he Funeral pletaly filled edical Co		yelclan: To the best of m niner: On the basis of exa and manner stated.	amination and/or i			place, and due to th	e cause(s) and m	anner as sta	ited.
To the Common	29b. Signature and title of certifier	A Na	de	29c. Licens O	e number C.M.E.		29d. Date signe JUNE 15		
0.65.6	30. Name and address of person who of Stephen 5. /	completed cause of death		Print)  Street,	Baltin	more, Mary	land 212	201	
State Registrar	31. Date tiled (Month, Day, Year)	32. Registrar's	Signature	B. do	all				



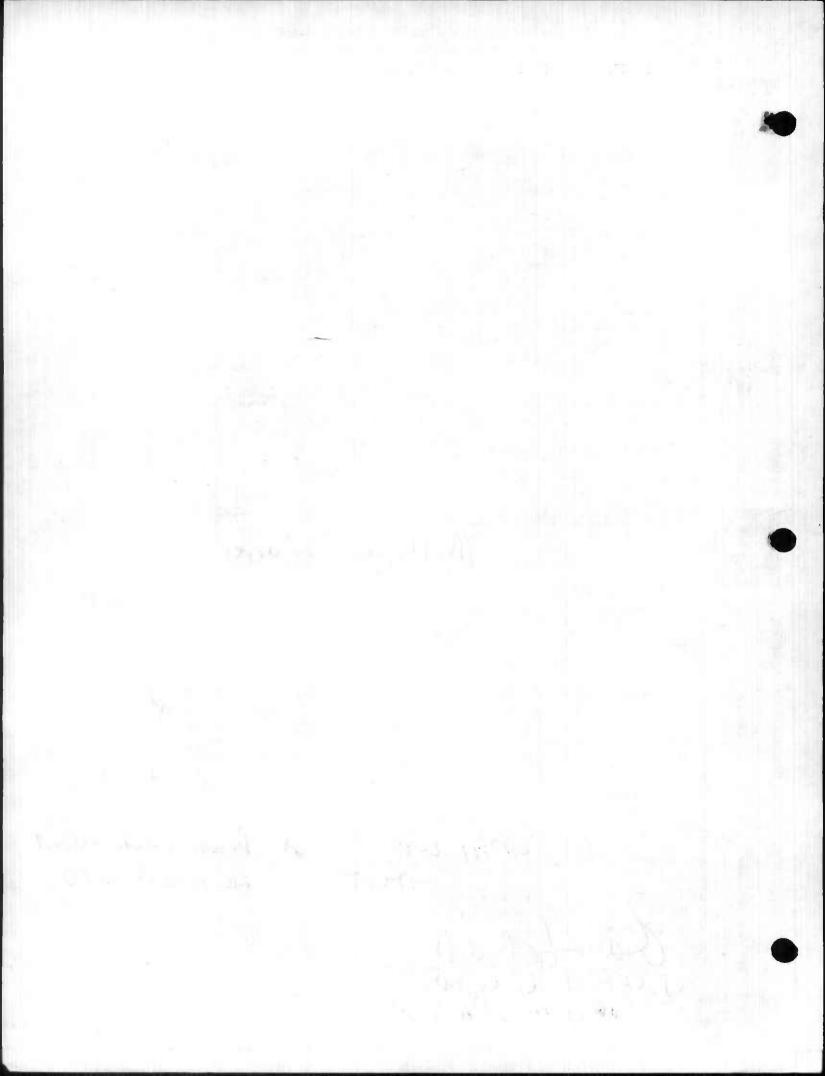
Records, P.O. Division n 24 hours after death. he Funeral Director: Afte pletely filled in by the fur Hospital within 2 To the

29c. License number 29d. Dete signed (Month, Day, Year) OCME JUNE 14, 1999 30. Name ed causa of death (Item 23a) (Type, Print) nd addressrof person 32. Registrar's Signature NO 31. Date filed (Month, Day, Year) 111 Penn Street, Baltimore, Maryland 21201 1999

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steled.

edical

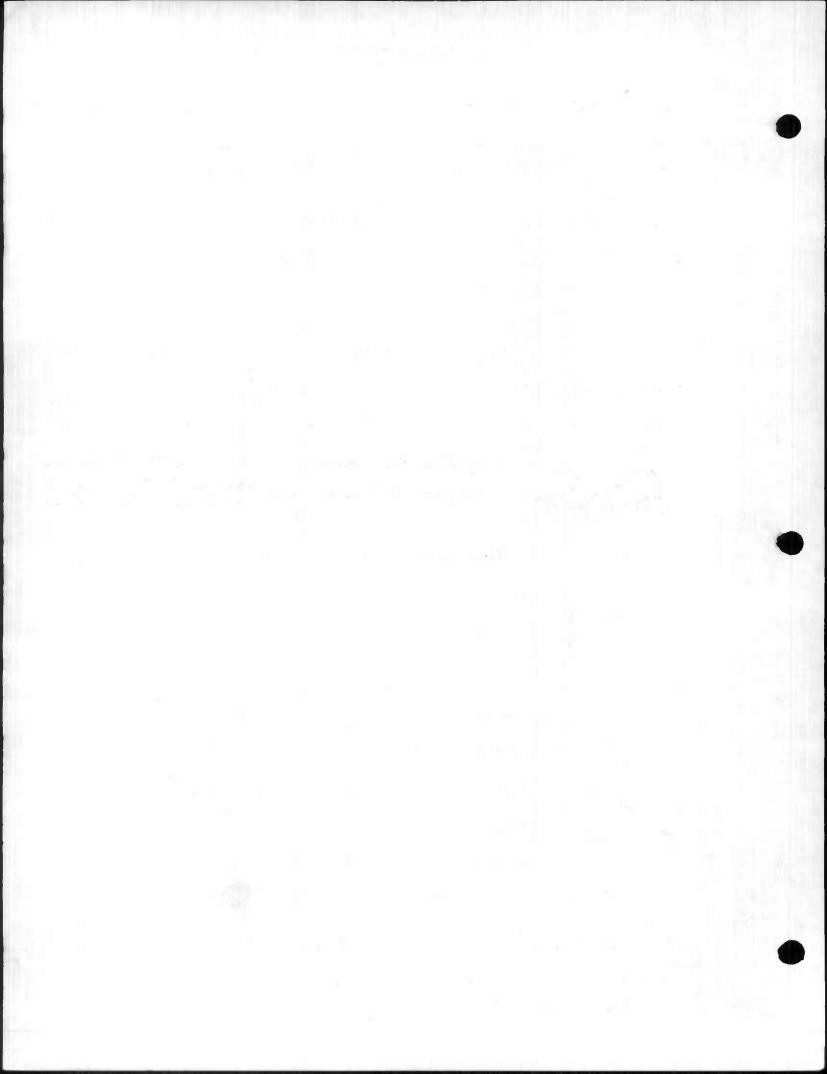
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State of Maryland / Department of Health and Mental Hygiene 9 9 2 1 0 2

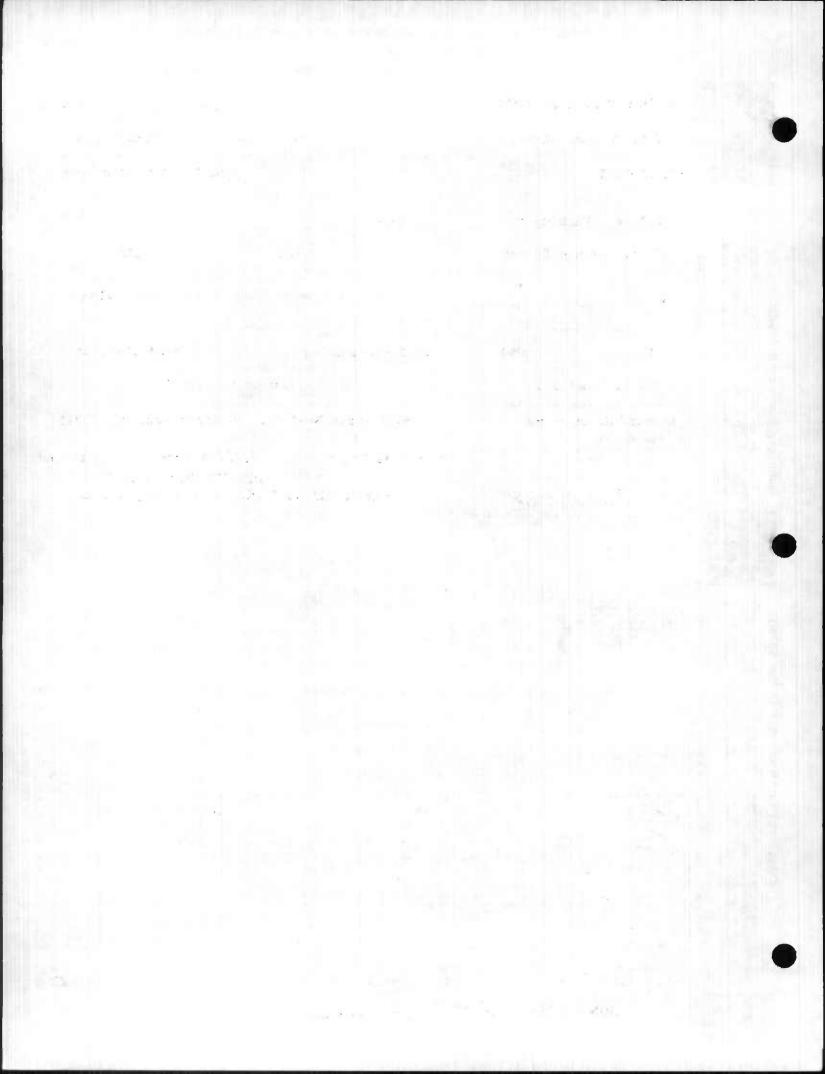
							C	ertificate	of De	eath		R	eg. No.			
	Dhysia	ion	1. Decedant's Nama (First, M	ddla, La	nst)							Data of Dea:		Vaar	3. Time of	f Death
	Physic /Medi		DOROTHY W	ille	nbucher	IML	AY					UNE	10 Day	1999	7:30	AM
	Exami		4a. Facility Nama (If not institu	ition, gi	a straat and numi	ber)			4b.	City, Town	n, or Locati	on of Daath	4c. County	of Death		
			19120 SWING	ING	BRIDGE R	ROAD				BO	OONSB	ORO	W	ASHIN	GTON	
	Funeral Director		5. Social Sacurity Number  215-54-9814  Usual Rasidance of Dacedan	1	Sex 7 1 □ M 2区 F	7. Aga (In yr. 74	s. last birthde Yrs.			f Undar 24 Hours	Min.	Data of Birth Month, Dey, B. 1,	1925	9. Birthp Coun NEW	elaca (Stata o etry) V JERS:	or Foreign
	the Maryland 28a-f ehow notified at	2	10a. Stata 10b. Cou	,		10c. C	City, Town or							1	0d. insida Cit	
	the M	ect		SHII	NGTON				NSBO	ORO						2001140
	with or	급	10e. Street and Numbar					10f. Zip Co				10g. Citizan of What Country?				
	a 23a	era.	19120 SWINGI	VG F						1713				U.S.A		
120	72 hours after death with the Maryland natural", or items 23s or 28s-f show after Examinet must be notified at	by Funeral Directo	11. Marital Status  1 □ Navar Marriad 2 □ N  3 ☑ Widowad 4 □ Divor		12. Was Daced Armed Ford 1 Yas 2 If Yas, Giva Yaar or Dat	eas? 2⊠No	U,S. 1	3. Was Decedan If Yas, specify 1 ☐ Yas 2 【		anic Origir Maxicen, F S <i>pecify:</i>	n? (Spacify Puarto Rice	Yas or No- in, atc.)		ce - Amaric ck, Whita,	atc.	
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Maryland	should be nd Mentel marked o	o Be	FRANZ O. WIL	FME	TCHED				18. Mother's Nama (First, Middla, Maidan Sumama)  AMY HART							
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Baitimore,	permit. Pegas 1 end 2: Depertment of Health a Important: If Itam 27 is any Injury or other trau		21. Signature of Funeral Serv	LI D		1 M. I	ean I	22. Nama and A BAST FUN					d Natio			13
			23a. Part1. Enter the disease shock, or haart failura. I	er com	plications thet ceu	usad tha dec	eth. Do not a	ntar tha moda o	dying, s	such as ce	ordiac or ra	spiratory arra	ast,	yranc	Approximate Interval Baty	
	Physician /Medical		Immediate Causa (Final disaasa or condition	ist only	a. A7		11 +			/-	1.5				Onset end D	Death
	Examiner		rasulting In death)		a		(or as a cons		000	colar	aise	ase			iongler	m.
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	certificate be axecuted ding physicien and ise as the buriel-transit	Examiner	b													
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00	ificet p phy as th	Medical	rasulting In daath) Last			Dua io (	or as a cons	aquance or).								
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0	eth.	atic		stigation		Doy roury	injury	М		2 🗆 No						
DIVISION	To the Hospital or Attanding Ph within 24 hours after deeth. To the Funeral Director: After th complataly filled in by the funeral	Certification:	3 ☐ Suicida 6 ☐ Cou 4 ☐ Homicida data	ld not b mined	28a. Place of	f Injury - At I g, etc. <i>(Spec</i>	homa, farm,	straat, factory, of	fice			28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)				
_	spita nours neral		29a. Cartifiar 1 Certif	/ing Ph	ysician: To the be	est of mv kn	owiedoa da	ath occurred at the	na time r	date and n	place and	fua to the ce	nusa(s) and m	annar ac ch	ated	
	Fur ataly	edical	(Check only 2 Medicone)	al Exam	niner: On the basi	is of axemin	ation end/or	invastigation, in	ny opinio	on, death	occurred a	tha tima, da	ata and plece,	and dua to	the ceuse(s)	.)
	ithin o the	Z	29b. Signatura and titla of cert	fiar	/ -			29c, 1 i	cansa nu	ımber		20	9d. Date signe	d (Month I	Dav. Year)	
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			1 021	1 6	gan				D 00	5265	579		6/10/	99		
			30. Nema and address of pers	on who												
			R. L. Kugler		747 N	orther	- Ave.	Hagar	tour	- , n	-d.	21742				
	Sta	ite	31. Deta filad (Month, Day, Ye	1 10	32. Reg	istrer's Sign	natura	3		T						



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State of Maryland / Department of Health and Mental Hygiene 9 2 1 0 3

						Certifica	te of	Death		R	eg. No.			
sician	1. Decedent's Name (First, Mic		TONEG	70.0				VALUE OF		ate of Dear	th Day	Yaar	3. Tima of Death	
edical	William Cleve								-17	whe	10	199	0606	
miner	4a Facility Nama (If not institute 277 S. Potoma	ALL PROPERTY.		er)				4b. City, Town, Hager:			4c. County	of Death shing	ton	
	5. Social Security Number	6. Sex		Aga (In yrs.	last birth		er 1 Yaa	r If Under 24 h		Date of Birth Month, Day			ace (Stata or Foreigny)	
eral tor	220-18-2145 Usual Residence of Decedent	1831	/ 2□ F		71 Y	Months	Days	S Hours N	din. (	an. 5	, 1928		land	
	10a. State 10b. Cour	nty		10c. Ci	y, Town	or Location						10	od. insida City Limit	
to	Maryland Wa	shing	ton			Hagers	town						Yes 2 N	
Director	10e. Street end Number 277 S. Potom	C4				10f. Z	ip Code	21740		1	Og. Citizen of V		try?	
era			, Was Decede	nt Ever in I	c	12 Was Dec	adent of		2 (Specify	Vee or No-		JSA e - America	an Indian	
by Funeral Director	11. Marital Status  1 Never Marriad 2 M  3 Widowed 4 Divorce	larried	Armed Force 1 Yes 2 If Yes, Giva Year or Date	as? □ No	.0.			Hispanic Origin? ban, Maxican, Pu Specify:	uerto Rice	n, etc.)		ck, White, a		
Completed	15. Deced	lent's Educe	tion		16e. [	Decedent's Us	ual Occu	upation	working		16b. Kind of Bu	usiness/ind	lustry	
nple.	Elementary/Secondary (0-12		College (1-4	or 5+)				during most of working						
	12 17. Father's Name (First, Middle	(act)	2		mas	ter as	semb	abler sand blasting  18. Mother's Neme (First, Middle, Maiden Sumama)						
o Be	David F. Jone									Bow		iaj		
۲			n. Print)		19b.	Meiling Addre	ss (Stree					Stata. Zip	Code)	
er trac	19a. Informant's Name/Relationship (Type, Print)  Leonard Jones – son  19b. Meiling Address (Street and Number or Rural Rolling Address)  19b. Meiling Address (Street and Number or Rural Rolling Address)  20a. Meiling Address (Street and Number or Rural Rolling Address)  20b. Place of Disposition (Nama													
3	20a. Method of Disposition				Place of I	Disposition (No. crematory or	ama of	(ace)	D	ate	20c. Location -	City or To	wn, State	
5	1 A Burial 2 ☐ Crematio 4 ☐ Donetion 5 ☐ Other		noval from Sta	ate		Hill C			6/1	1/99	Hagerst	own,	faryland	
SDC6.	21. Signetura of Funeral Service	ce Licensee						ress of Facility			UNERAL rstown,		21740	
	23a. Part1. Enter the disease, shock, or heart failure. L			sed the daet	h. Do no	ot enler the me	ode of dy	ring, such as car	diac or re	piratory arr	rest,		Approximete Intervel Between	
an								0					Onset and Death	
er er	Immediate Cause (Final disease or condition rasulting in death)	a.	Ce	ubr	04	sall	or	bu	ide	w			hours	
	rasulting in Gaatily			Dua to	or as a co	onsequance of	f): .							
edical Examiner	6 Sypertención y												years	
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edical	thet initiated events	C		Due to (c	rasaco	nsaquenca of	):							
Med	rasulting in daeth) Lest			,										
any		d										1		
Physician/	Part II. Other significant cond	itions contr	buting to deat	h but not ras	ulting in	the underlying	ceuse	given in Part I.		23b. Did to	obacco use co	ntribute to	the cause of deat	
/ Physician/		T	0 4	2	.01	1.4	,			150	es 2 No	3 Prot	pably 4 Unkno	
۵	V	tia	files			JUL				24a. Was a	no outoney	24h Wa	ere autopsy findings	
Completed									_	perfor	med?	eva	alleble prior to inplation of ceuse	
du.											~/		death?	
္မ	25. Was cesa rafarrad to medi	ical						OC Plans of	Dooth (C)	1 🗆 Y	/ \	11	Yes 2 No	
	axamiper?		spital:	ationt 2	EB/Out	patient 3 0	70A C	26. Place of other:		-	ance 6 □Oth	er (Specifi	<b>/</b> 1	
Be			28e. Date of	Injury	28b. Ti	ma of	28c. Inj				ow injury occur		7	
To Be	1 ☑ Yes 2 ☐ No 27. Manner of Death			Day Year)	In X	/ M	N	TYES 2 No		1	A			
To Be	1 Yes 2 No  27. Manner of Death  Netural 5 Pan	ding stigation	7-1	A	/							acar Dum	I Davida Alivana	
To Be	1 Ves 2 No  27. Manner of Death  1 Netural 5 Pan 2 Accident Inve		28e. Piece of		ome, fari	n, street, facto	ory, office	a	28f.	Location (S City or Tow	treet and Numb n, State)	er or nura	Houte Number,	
Certification: To Be	1  Yes 2 No  27. Manngr of Death  1 Netural 5 Pan 2 Accident Inve 3 Suicide 6 Cou 4 Homicide	stigation ild not be ermined	28e. Plece of building	Injury - At h , etc. (Special	(y)	MA				City or Tow	n, State)	-		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month OHNSON 1:00AM 1 UNE /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Deys 1 M 2 F 216-07-053 Yrs. Director Usual Residence of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Maryland sent of Health and Mantal Hygiena. nnt: If item 27 is marked other than "natural", or frems 23s or 28s-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Rems 23s or 28s-f show Ma 1 Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5608 Completed by Funeral Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status traumatic event, the Medical Examiner 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married ŏ 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) UNKNOWN 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Health a : If itam 27 is or other train 5608 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department o Important: If any injury or 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licenses Chape 23a. Pert f. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete interval Between Onset and Deeth **Physician** /Medical immediate Cause (Finai diseese or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Fibrillation Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or es a consequence of): · Allheimer's Physician/Medical Due to (or as e consequence of) eta has been signed by the attending popula page 2 should be detached for use as t Part ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificeta 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) 1 ☐ Yes 2 🕏 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After ! 5 Pending investigation 1 Naturai 1 TYes 2 No 2 ☐ Accident s efter daath 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, To the Hospital of within 24 hours e To the Funeral D

Baltimore, Maryland 21215-0020

State Registrar

Medicai

29a. Certifier (Check only one)

29b. Signature and title of dertifier

30 Name and address of person who

31. Dete filed (Month, Day, Year) 0 2 1999

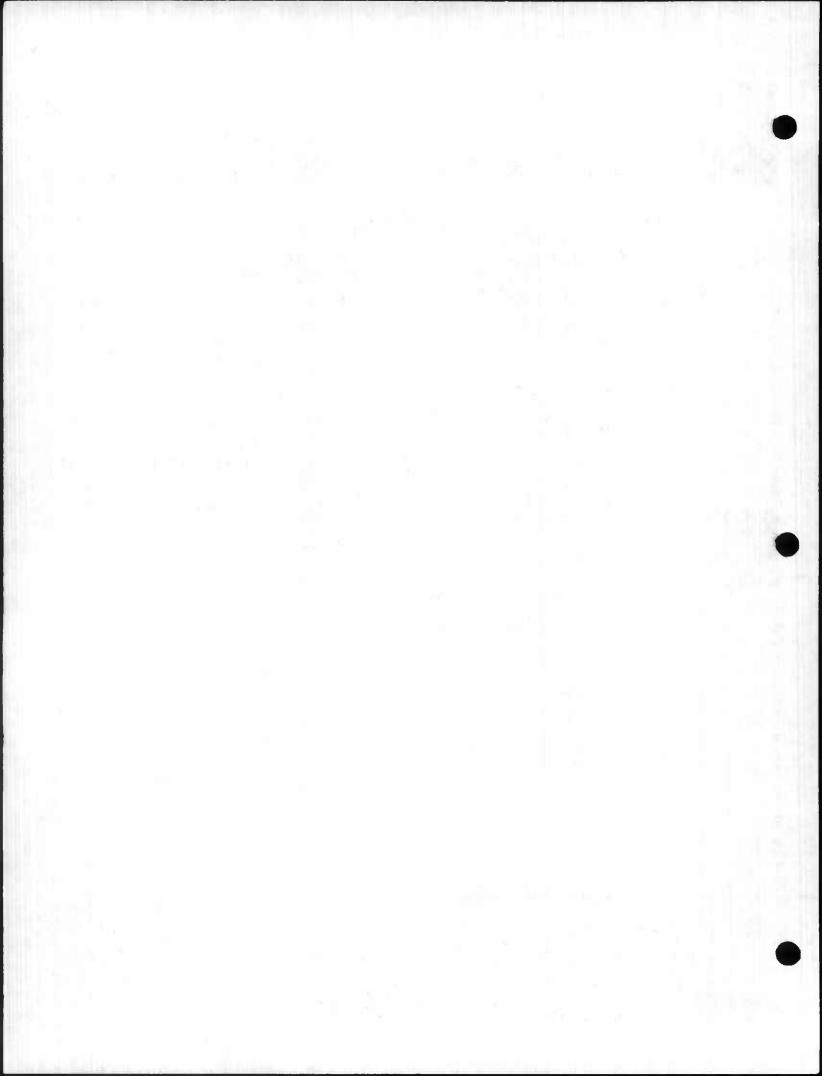
1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) end manner stated. 29c. License number

29d. Date signed (Month, Dey, Yeer)

completed cause of death (item 23a) (Type, Print)

daath.



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 11:20 P.M. 21, 1999 Clarence Matthews Knox June /Medical 4a. Feclity Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Homewood Retirement Center Williamsport Washington H Under 1 Yeer | H Under 24 Hrs. | 8. Date of Birth | Months | Deys | Hours | Min. | May 22, 1907 5. Sociel Security Number 7. Age (In yrs. last birthdey) 9. Birthpiece (Stete or Foreign Funeral 1 M 2 □ F 215-20-9486 A Maryland Director Usual Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inaide City Limita nd other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 27 E. Magnolia Avenue 21742 USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Bleck, White, etc. 1 ☐ Yes 2 ☐ No 1 ☐ Never Merried 2 ☑ Married 1 ☐ Yes 2 Ø No Specify: Specify: þ White 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Eiementery/Secondery (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed wit Department of Health and Mental Hygiene Important: If itam 27 is marked other tha any fujury or other traumatic event, the 1 once. Teacher Board Of Education 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be George Bernard Knox Fannie Matthews 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Addresa (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) ife 27 E. Magnolia Avenue Hagerstown Md. 20b. Piece of Disposition (Name of cametery, cremetory or other place) Dete 20c. Location - City or Town, State Madeline C. Knox Wife Md. 21742 20e. Method of Disposition 1 Sp Burlei 2 □ Cremetion 3 □ Removei from Stete 4 □ Donetion 5 □ Other (Specify) St. Benjamins Lutheran Ch. Cemetery 6/26/99 Kriders, Maryland 21. Signature of Funeral Service License 22. Neme end Address of Fecility Gerald N. Minnich 305 N. Potomac Street 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or shock, or heart feiture. List only one cause on each line. Hagerstown, Maryland 21740 respiratory errest, Approximate **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in deeth) Examiner Due to (or es e consequence of) Examin buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated eventa resulting in death) Lest Due to (or es e consequence of): Physician/Medical the Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 Probably 4 Unknown 2 24b. Were autopay findings available prior to completion of cause of deeth? Completed 24a. Wes an autopsy 1 Yes 1 ☐ Yea 2 ☐ No Be 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) 1 Yes 2√ No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28e. Dete of injury (Month, Dey Year) 28b. Time of injury 28d. Describe how Injury occurred Certification: 28c. injury et Work? 1 Neturel 5 Pending investigation 2 Accident 1 Yes 2 No 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Baltimore,

9

signed by pege 2 should be certificate Attending Physician: this death. I Director: A 8 To the Hospital within 24 hours a To the Funeral C completely filled Hospital

> State Registrar

Medicai

4 Homleide

29b. Signeture and title of cartified

29e. Certifier (Check only

30. Mama s

Dete liied (Month, Day, Year) JUN 2 3 1999

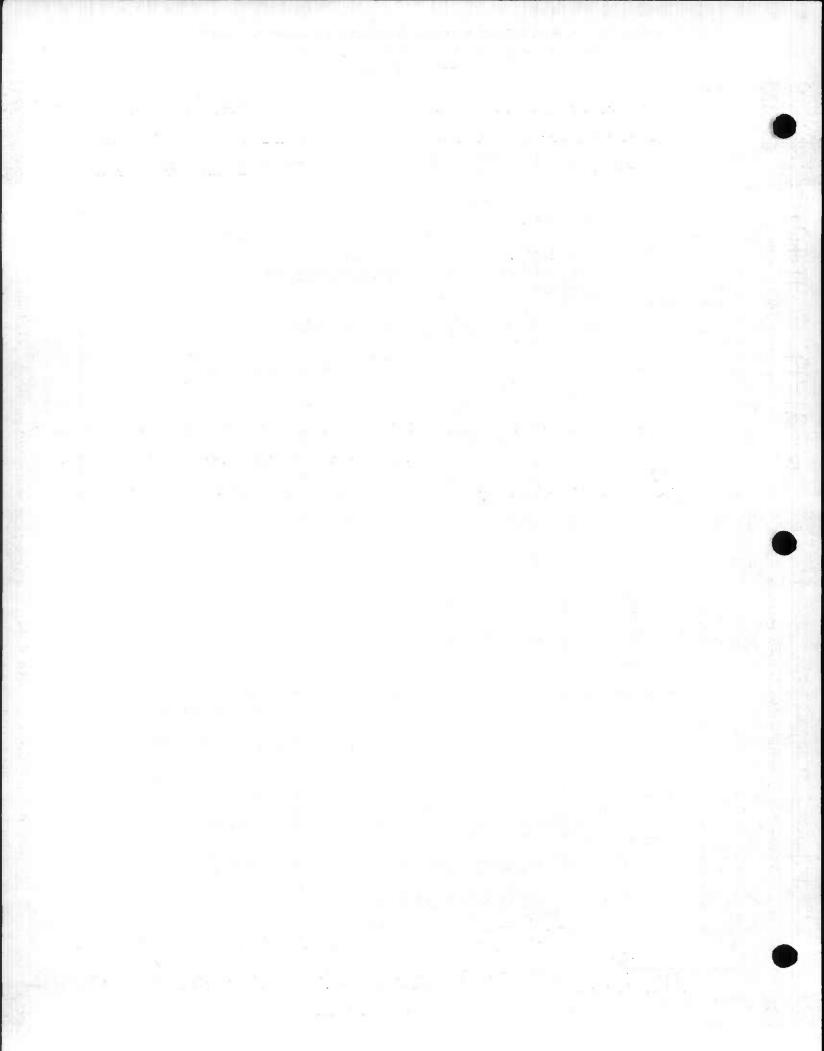
32. Registrer's Signature

end menner steted.

1/2 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner, On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s)

29c. License number

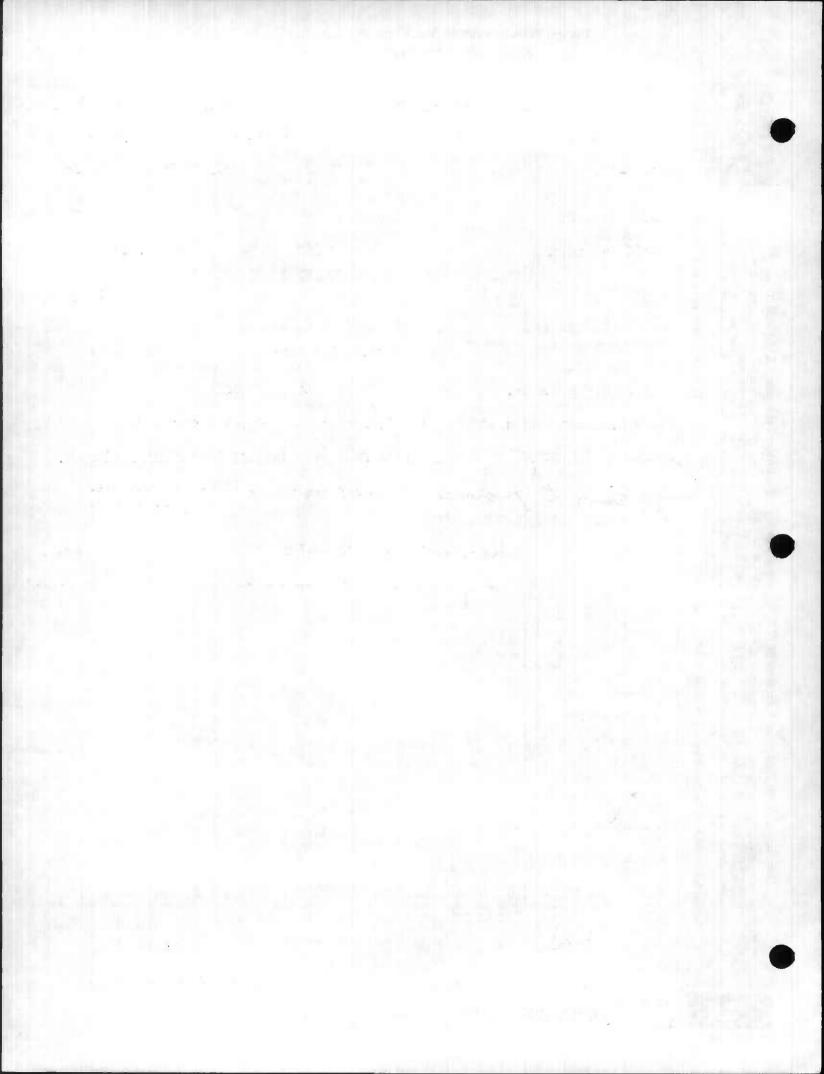
29d. Date signed (Month, Dey, Year)



### Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 2 1 1 0 6

		Decedent's Name (First, Middle, Lass)	9	Ce	ertifica	te or	Death	2. Dete of D	Reg. No.		3. Time of De	eeth
Physician	1	DONALD GE		LE SI	З.			JUNE JUNE	20, 19	Yeer 99	111111111111111111111111111111111111111	AM
/Medical Examiner		4a Facility Name (If not institution, give Frederick N	street and number) lemorial Hospi	tal			4b. City, Town, or Freder		th 4c. County			
Funeral Director		220 01 0111	7. Age (In yrs.	last birthday Yrs.	) If Undo	Deys	If Under 24 Hrs Hours Min.	8. Dele of Bi	15,1936	9. Birthr	piace (Stete or Fo Lyland	oreign
the Maryland 28a-f show nothing at		Usual Residence of Decedent  10a. State 10b. County  Md. Washing		ty, Town or L	ocation aveto	พท				1	10d. Inside City L	
ufer death with the Mar r items 23s or 28s-f si incomment Director	an Dillect	10e. Street and Number 22416 Goose St.				ip Code	720			of What Country?		
urs a	2	11. Maritel Status  1 Never Merried 2 Married 3 Widowed 4 XDivorced	12. Wes Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	l,S. 13	Wes Dec If Yes, sp		dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or N to Rican, etc.)	o- 14. Reca Blac Specify	k, White,	can Indian, elc. ute	
	minimered	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)				petion during most of wa d) erator	16b. Kind of Business/Indu				
ad other	0	17. Fether's Neme (First, Middle, Last)  Martin (1) Kondlo	Sh			0 0 0	18. Mother's Ne		e, <i>Meiden Sum</i> em		,,,,,,	
2 shot 2 shot 1 and h	-	cometery, cremetory or other place)										
Defiumore, in semit. Pages 1 and Department of Health important: if Item 27 any injury or other 1 and 266.		20a. Method of Disposition	20b. I	Plece of Disponentery, con	osition (Nemetory or	ome of other ple	ce)	Date		City or To		
permit. Pa Department Important any injury once.	4	21. Signature of Funeral Service Licent	Jours				eral Hom	e 12525 Smith	Bradbury sburg, Md.	AUG 217	2.	
Physician		ert1. Enter the disease, or comp shock, or heert feilure. List only of						c or respiratory	errest,		Approximate Intervel Betwee Onset and Dee	en eth
Examiner		Immediate Ceuse (Finel disease or condition resulting in deeth)	RESPIR	nr es a cons	equence of						1 How	,
executed on end ist-transit		Sequentially list conditions	b. Due to (or es a consequence of): Preumo m bue to (or es a consequenca of):								Imonl	W
physicie s the burn		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest  Due to (or as a consequence of):  Due to (or as a consequence of):									Doug	
attending for use a	Idivin	The Sand	d									
d by the detached		Pert II. Other significant conditions co Demen ta	ntributing to death but not res	sulting In the	underlying	cause gi	ven in Pert I.		tobacco uss cor	3 Pro		
Physician: The law requires that the deeth cent this certificate has been signed by the attending director, page 2 should be detached for use.	bieren Di							24a. Wa	s en eutopsy formed?	an Co	Vere autopsy find veilable prior to ompletion of caus f deeth?	
The ate h									Yes 2 No	1	☐Yes 2☐ No	)
Physician: this certific ral director,	2	25. Wes case referred to medical exeminer?  1 Yes 2 No  27. Manner of Deeth	Hospitel: 1 Inpatient 2	ER/Outpeti		JUA	ner: 4 Nursing		sidence 6 Other		ify)	
bal or Attending P is after death.  al Director: After the din by the funera	Casion	1 Meturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Dey Year)  28e. Pieca of Injury - At h	Injury ome, ferm, s	М		rk?  Yes 2□No	28f. Location	(Street end Numb		ral Route Numbe	or,
To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	200	29a. Certifier 1 Certifying Phy	building, etc. (Speci	fy) owledge, dec	th occurre	d et the ti	me, dete and piec	e, end due to the	own, State) e ceuse(s) and me	nner as :	stated.	
the Hospit thin 24 hours the Funer empletely fill		29b. Signature and title of certifier	ner: On the basis of exemine end menner steted.	etion end/or I								
T W T		bol				D4'	3091		29d. Date signer 6-20-	99	, - aj, 1 (al)	
		30. Name and eddress of person who c	TAID! ME		Print)	T	ou Hor	KE A	ve fre	de	ich	
State Registrar		31. Dete filed (Month, Dey, Year)	32. Registrar's Sign		4	1						



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death 13, 1999 June Sadie Marie KLINE 4:10pm 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Smithsburg 13341 Wolfsville Road Frederick 8. Data of Birth (Month, Dey, Year) July 20, 1924 5. Sociel Security Number If Under 1 Year Birthplaca (Stata or Foraign Country) 7. Age (In yrs. lest birthday) 1 M 2 XF Months Deys Hours 74 Yrs. 220-16-3895 Maryland Usual Residence of Decadent 10h County 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Frederick Smithsburg 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 13341 Wolfsville. Rd. 21783 U.S.A 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yaer or Detes: 14. Raca - American Indien, 11. Meritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, Whita, etc. 1 ☐ Nevar Merried 2 ☐ Married 1 ☐ Yas 2 ☒ No Specify: Specify: White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Inspector Book Co. 18. Mother's Neme (First, Middle, Maiden Sumama) 17. Father's Neme (First, Middle, Last) Frank Benjamin Huntzberry Bertha Mae Showe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Paul Kline III (Son) 3208 Garfield Rd. Smithsburg.Md. 21783 20b. Place of Disposition (Nama of cemetary, crematory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Stete K Berm **©** Cremation 3 Pemoval from State St. Mark's Lutheran Cem. June 16,99 Wolfsville, Md. Donation 5 Other (Spec 22. Name and Addrass of Facility 21. Signature of B 12525 Bradbury Ave. maral German Tox Davis Funeral Home Smithsburg, Md. 21783 Pert1. Enter the disasse, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failura. List only one causa on each line. Approximata Interval Batween Onsat and Death Immediata Causa (Final disaasa or condition rasulting in daath) Ventricular Arrhythmia Immediate Due to (or es e consequenca of): Arteriosclerotic Cardiovascular Disease Years Sequentially list conditions, if eny, laading to immadiate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consaquenca of): Due to (or es e consequenca of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 1 Unknown 24b. Ware eutopsy findings evaileble prior to completion of cause of daeth? 24a. Was an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Piece of Deeth (Check only one)

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

þ

Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Hestin and Mental Hygiena. Important if Item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumstic event, the Medical Examinet must be notified at

Baltimore, Maryland 21215-0020

Examiner and I-transit physician ar s the burial-to 88 attanding | been signed by tha s should be datached ete hes l is cartificate h To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifice complately filled in by the funeral director;

The law requires that the death cartificeta be axecuted

Division of Vital Records, P.O. Box 68760,

Physician/Medical à Completed Be 2 Certification:

Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i.

Diabetes: Thrombocytopenia

25. Wes case referred to medical 1 XYes 2 No

27. Menner of Deeth 5 Pending invastigation 1 Natural 2 Accident 3 Suicide

4 Homicide

29a. Certifier

6 Could not be datarminad

1 Inpatiant 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Day Year)

28b. Time of

28a. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

28d. Describe how Injury occurred

Other: 4 Nursing Home 5 AResidence 6 Other (Specify)

2 Madical Examiner: On the basis of axemination end/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, and due to the ceuse(s) and mannar steted. 29b. Signature and title of certifier

29c. License number D35164

1 Certifying Physician: To tha bast of my knowledge, deeth occurred et the time, dete end pleca, and due to the ceuse(s) end mennar as stated.

29d. Date signed (Month, Day, Year) June 15, 1999

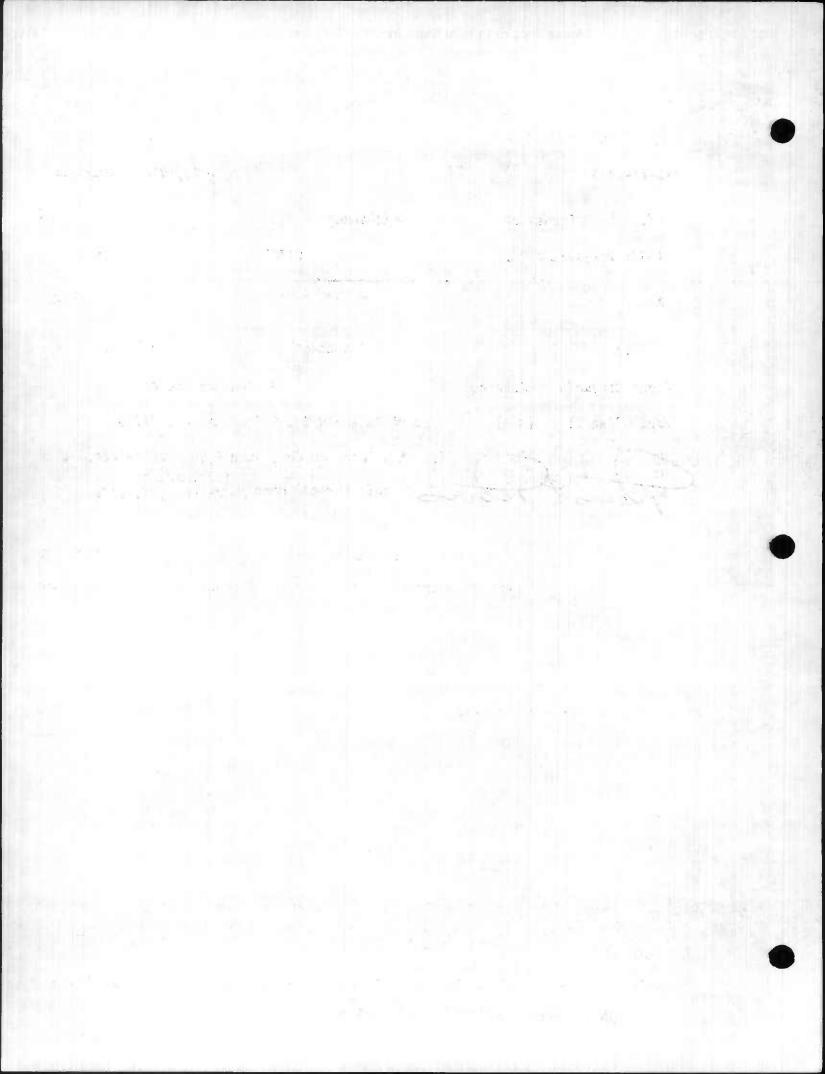
30. Nama end address of person who complated cause of death (Itam 23a) (Type, Print)

M.D., 1080 West Patrick Street, Frederick, Maryland 21703 Andrew Zarick, 31. Data filad (Month, Day, Year)

State Registrar

JUN 1 7 1999





### Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 1 Tey Month 1999 Mary Lorraine Kipe June 2:15 A.M. 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Williamsport Nursing Home Williamsport Washington | H Under 1 Yeer | H Under 24 Hrs. | 8. Dete of Birth | Months | Deys | Hours | Min. | July 29, 1920 9. Birthplece (State or Foreign Country) Maryland 7. Age (In yrs. lest birthdey) 1□ M 2□√F 78 Yrs. 10b. County 10c. City, Town or Location 10d. Inside City Limits Washington 1 ☐ Yes 2 No Hagerstown 10f. Zip Code 10g. Citizen of What Country? 21526 Leitersburg-Smithsburg Rd. 21742 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 XNo Specify: White 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Plastic Co. Secretary 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) Levi Myers Hartle Beulah Mae Newcomer 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Paula Kay McCall (Daughter) 21317 Leiter St. Hagerstown, Md. 21742 20b. Plece of Disposition (Neme of cemetery, crametory or other place) 20c. Location - City or Town, Stete 1 Surial 2 Cremetion 3 Removel from Smithsburg Crematory June 13, 1999 Smithsburg, Md. Signature of Funeral Service License 22. Neme end Address of Fecility Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth . Cancer of the pancreas and gall bladder MONTHS Due to (or es e consequence of): Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24e. Was en autopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 28. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28e. Dete of injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Yes 2 No

**Examiner** physician end the burial-transit Vital o After Attending death. Hospital or Attend 24 hours after death Funeral Director: To the Hospital o within 24 hours af To the Funeral D completaly filled i

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

238

7 is marked other than "natural", or items 23s or 28s-f shor traumatic event, the Medical Examinar must be incitied at

'natural', or

permit. Pages 1 and 2 should be filed within: Department of Haalth and Mental Hygiera. Important: If Item 27 is marked other than "rany Injury or other traumatic event, the Head

**Physician** /Medical

Baltimore, Maryland 21215-0020

Eleven

5. Sociei Security Number

219-20-1766

10e. Street end Number

20e. Method of Disposition

Immediate Cause (Final disease or condition resulting in death)

10e Stete

Director

Funeral

by

Completed

Usuel Residence of Decedent

Examiner Sequentielly list conditions, it eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Physician/Medical Completed by 25. Wes case referred to medical exeminer? Be 1 Yes 2 No Certification: To 27. Menger of Deeth 1 Neturel 2 Accident 3 Suicide 4 - Homicide edicai

5 Pending investigation 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 29e. Certifier 🔀 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29b. Signeture end title of certifier 29c. License number

29d. Dete signed (Month, Day, Year)

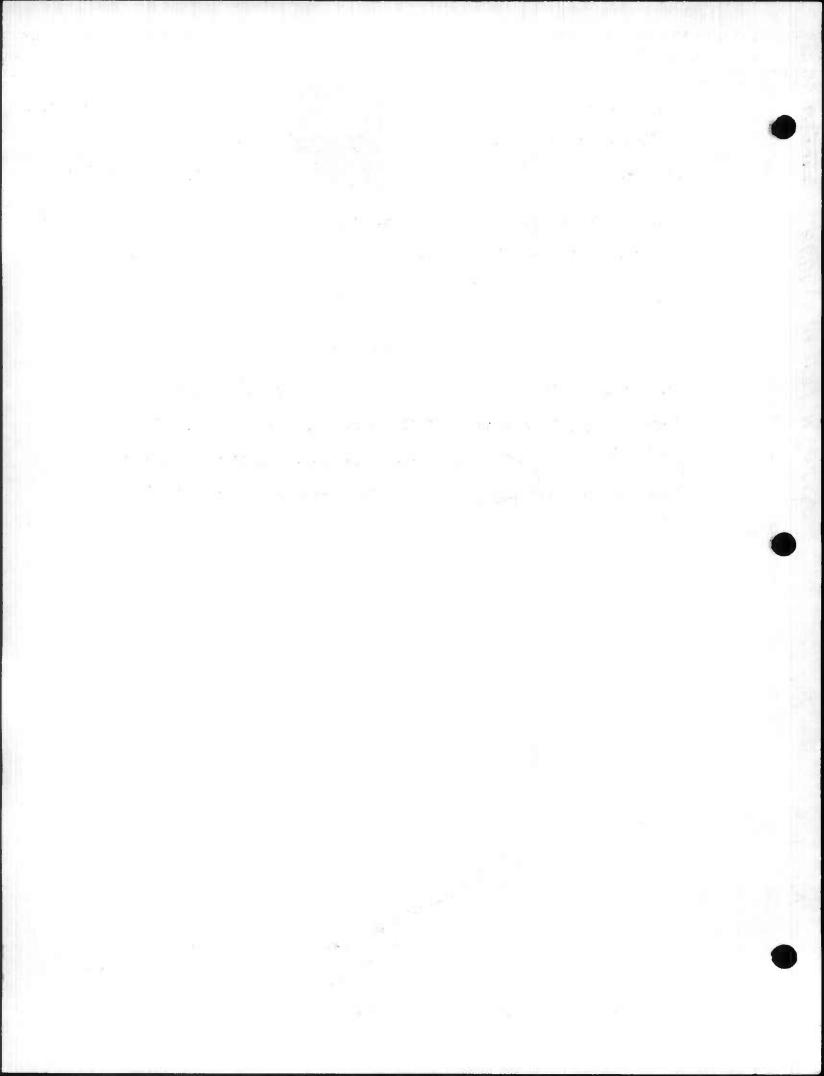
Cynthia Kuttner - Sando, mo 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

June 24, 1999

Hagerstown, Cynthia Kuther-Sands no 11110 Medical Campus Road, Suite 130, Maryland 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture JUN 2 5 1999

D47451

State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth **Physician** Mary Eileen 1999 4:00 A.M. JUNE /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Saint Mary's Hospital Leonardtown Calvert If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Defe of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Deys Hours 1□M 201 F Yrs. Director 216-18-9070 Nov. 21, 1922 | Maryland Usuei Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Meryland nent of Health and Mental Hygiene. Intent of Health and Mental Hygiene. Int: If flam 22 is a restricted other than "naturel", or flame 23a or 28a-f ahow ury or other traumatic event, the Medical Experiment must be notified as 10a. Stele 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 € No Directo Maryland Calvert Lusby 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 575 Lake Drive 20657 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Yeer or Detes: 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indian, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White à 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore Housing Elementery/Secondery (0-12) College (1-4or 5+) 12 Secretary Authority 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be George Carroll Schaub Rosina Elizabeth Sellman 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 13712 John Cline Road, Smithsburg, Maryland 21783 F. James Marecki III - Son 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 ☐ Burial 2 X Cremetion 3 ☐ Removel from State Department of important: If any injury or once. Metropolitan Crematorium 6/13/99 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funadal Service Licesaee 22. Name end Address of Facility Olin L. Molesworth P.A., Funeral Home 23a. Pert1. Exter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory erresi, shock, other lailure. List only one cause on each line. 20872-011 Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examine Due to (or a consequence of): Examiner physician and the buriel-transit Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lasf Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): use as Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? signed by the 20 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were eutopsy findings available prior to Completed 24a. Wes en eutopsy completion of ceuse of death? 1 Yes 2010 25. Wes case referred to midicel examiner? or Attending Physician: funeral director, Be 26. Plece of Deeth (Check only one) 1 Yes 2 NO Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Impatient 2 ER/Outpatient 3 DOA After this 28e Oate of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Naturel 5 Pending investigation 1 Yes 2 No deeth. 2 Accident ofter deeth Director: 6 Could not be determined within 24 hours effer developed To the Funeral Director completely filled in by the 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital Certifying Phyeiclan: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner es stated.

2 Medical Examiner: Or fire basis of examinetion and/or Investigation, in my opinion, deeth occurred at the time, dete end plece, end due to the cause(s) and manner action. 29a. Certifier edical To the 295. Signature and title of coailto 29c. License number 29d. Dete signed (Month, Dev. Year) 30. Name god address oppo cause of death (Item 23a) (Type, Print)

MARY'S MEDICAL ASSOC.

WILDEWOOD CTR, CALIFORNIA, MD

20619

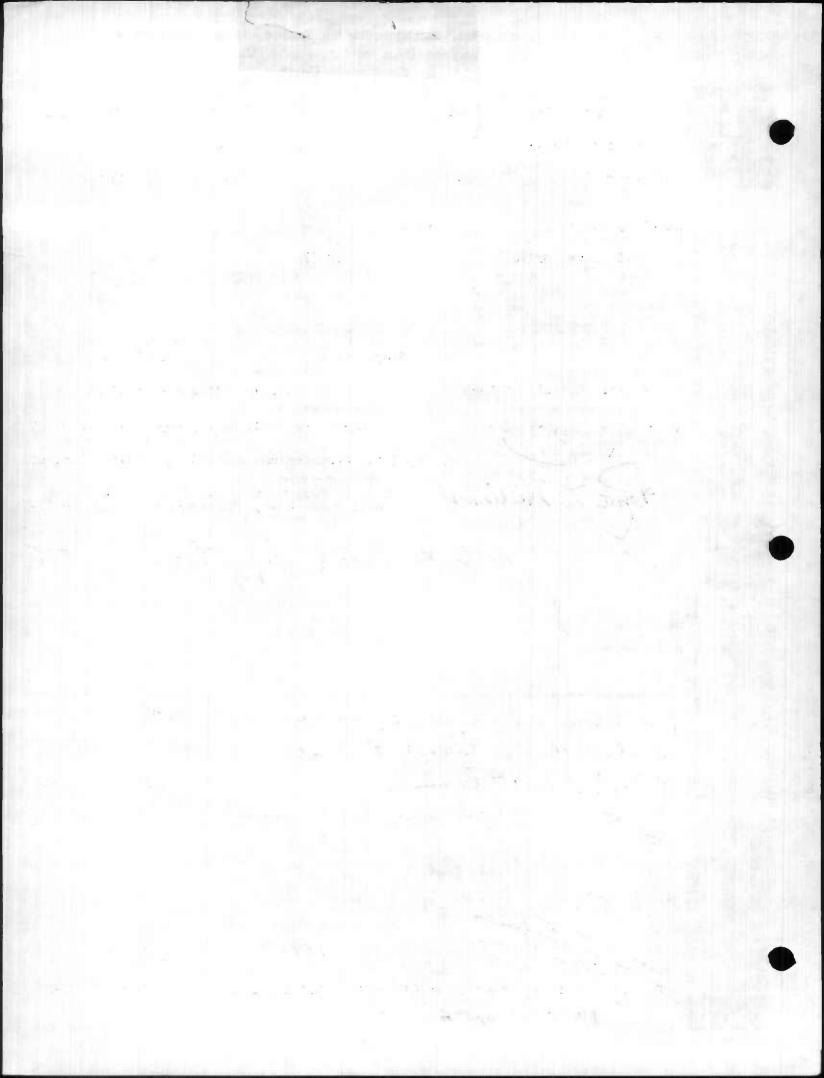
State Registrar DR. JAMES BOYD

JUN 1 6

51. Date filed (Month, Day, Year)

MARY

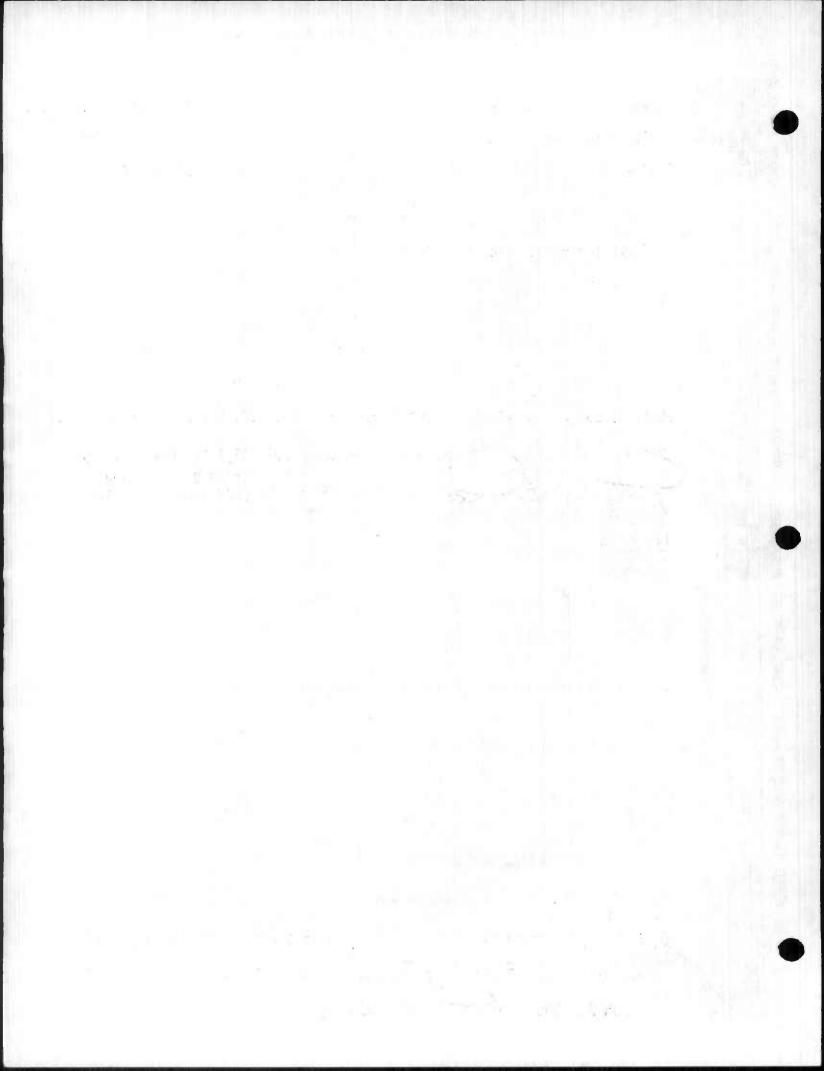
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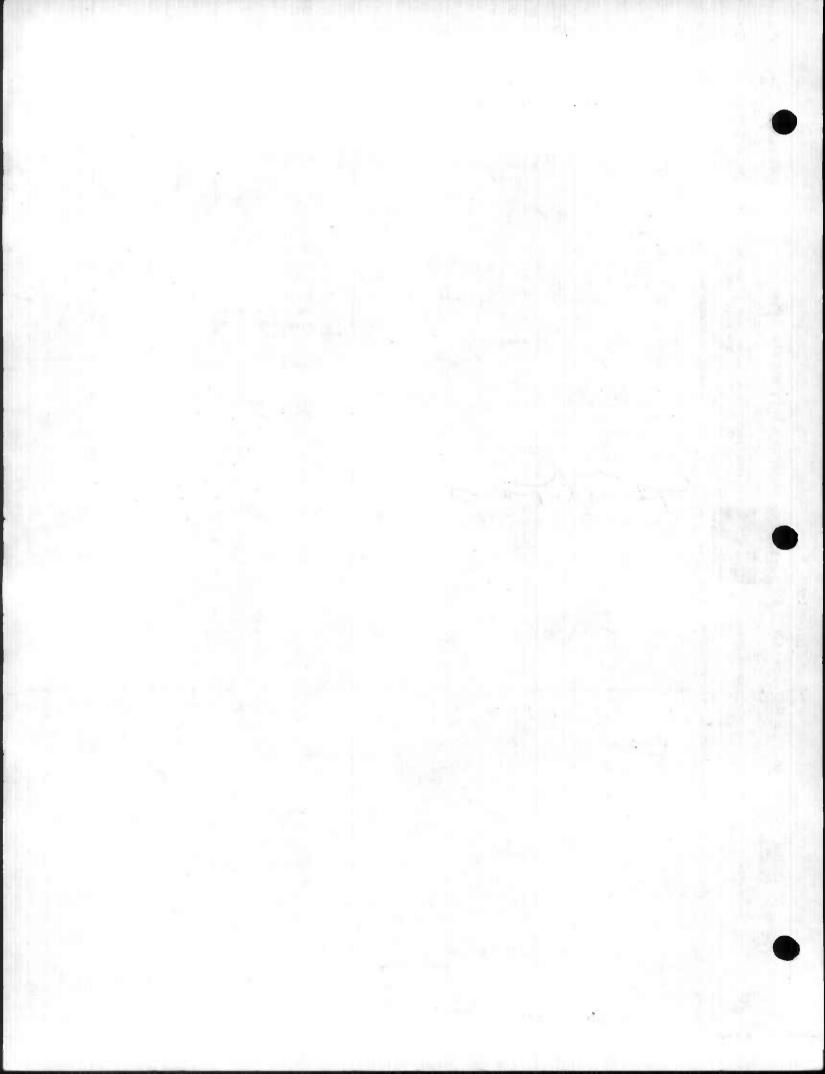
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 2 1 1 0

						Cei	tificate	e of	Death		Re	g. No.	to a		
	Db		1. Decedent's Name (First, Midd	lle, Last)						2.	Data of Deat	h	METER	3. Time	of Death
	Physic /Med		Rachel Rae	Longnecker						J	Month UNC	18	1999	6:00	P.M.
	Exami		4e. Facility Name (If not institution		)				4b. City, Town,		ion of Deeth	-	y of Death	,	
	DO W	9	12017 Long	necker Lane					Chews	vill	e	Wa	shing	ton	
	。Funeral Director		5. Social Security Number  215-42-3803  Usual Residence of Decedent	6. Sex 7. A 1 □ M 2 ☑ F	ge (In yrs. 82	last birthday) Yrs.	If Under Months	1 Yeer Days	If Under 24 Hours	Hrs. 8. Vin. D	Date of Birth (Month, Day, CC. 16	Y9916	9. Birthp Mary	place (State	or Foreign
	land		10a. State 10b. Count	/	10c. Cit	y, Town or Lo	cation						1	0d. Inside (	City I imits
	the Mary 28a-f sh	ector	Md. Was	hington		Chewa	sville							1 🕸 e	s 2 No
	s 23a or	Funeral Director	12017 Long	necker Lane				2172	- '			og. Citizen of	S.A.	ntry?	
21215-0020	I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.  Set 27 is marked other than "natural", or items 23a or 28a-f show ther traumetic event, the Medical Examinate must be notified at	b	11. Marital Status  1 □ Never Married 2 □ Ma  3 □ Widowed 4 □ Divorce	W Vac Give	?,	11	Vas Daced Yes, speci		dispanic Orlgini an, Maxican, P Specify:	? (Specifi uerto Ric	y Yes or No- an, etc.)		ce - Americ ick, Whita, fy: Wh		
2	natu dica	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)		16a. Deced	ant's Usua kind of worl	l Occup	pation during most of d)	working	1	6b. Kind of E	usiness/ind	dustry	
121	within	E G	Elementary/Secondary (0-12)	Collage (1-4or	5+)	life. L						.,			
N	lled v		12 17. Fether's Name (First, Middle	(act)			Homer	mare		Mana /	Zana a statuti ( a s	Hoi	_		
Maryland	should be filed within to Mental Hygiene. marked other than matic event, the Mental Control of the Mental cont	To Be	Simon P. Eccar	d		18. Mother's Name (First, Middle, Malden Surname)  Mollie M. Lewis  19h Mailinn Address (Street and Alumbar or Flum Foute Alumbar City or Tourn State Tin Code)									
, Mar	s 1 and 2 should be filed within 72 hr I Health and Mental Hygiene. 1am 27 is marked other than 'netun other traumatic event, the Medical		19a. Informant's Name/Relation Robert E. Long			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12017 Longnecker Ln. P.O. Box 39 Chewsville, Md. 2								. 2172	
E E	Pages nent of int: If it iry or c		20a. Method of Disposition  1 X Burial 2 Cremetion	3 □Removal from State	C	b. Place of Disposition (Name of cometery, crematory or other place)  Mt. Bethel Cemetery June 23, 1999 Foxville, Md.									
Ball	permit. Pag Department Important: If any Injury o		Signature of Funeral Service Licensee Davis Funeral Home Smithsburg, Md. 21												
	Physician /Medical		23a. Junt 1. Enter the disease, o nock, or heart failure. Lis	complications that cause only one cause on each I	d the death	n. Do not <i>e</i> nte	er the mode	of dylr	ng, such as cer	diac or re	spiratory erre	st,		Approxima Interval Ba Onset end	tween
	Examiner	D.	diseasa or condition resulting in death)	a	Due to (o	s as a consequ			Aire	ise	_		-		
o,	an and fai-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ſ	Due to (a	Due to (or as a consequence of):									Ħ
x 58760,	ding physician and se as the burishtran	/Medical	Cause (Disease or injury that installed events resulting in death) Last	( ,	Due to (or	as a consequ	ience of):								
ň	the death or y the attend sched for us	Physician	Part II. Other significant condition	one contributing to death b	out not resu	illing in the un	derlying ca	use giv	en in Part I.		23b. Did tob	ecco use co	ntribute to	the cause	of death?
L	deta deta	by Ph									1□ Ye	8 2 WO	3 □ Prot	sebly 4	Unknow
	aw megu sa been 2 shoul	Completed								-	24a. Was an perform	autopsy ed?	ava con	are autopsy slisble prior epletion of death?	to
	e - L	E O									1□ Yes	2DMS	10	Yes 20	No
		Be	25. Was case referred to medica examiner?	E L					26. Place of I	Death /C	heak anly one	J.	1		
	W 0	0	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inputio	ent 20	ER/Outpatient	3€ DOA	A Oth	er: 4 Nursin	g Home	5 Mesiden	on 6 00th	er (Specify	d	
	After		27. Manner of Death  1 ≪ Natural 5 ☐ Pendir 2 ☐ Accident investi		y Year)	26b. Time of Injury	M 28	la. Injun Worl	yaat k? Yes 2 ⊡ No	28d	Describe how	v injury occur	red		
5	s after de il Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be ined 28e. Place of In building, et	ury - At ho c. (Specify	me, farm, stre )	et, factory,	office		281	Location (Stre City or Town,	eet and Numb State)	ber or Rura	i Route Nun	nber,
	of the rooptes of Attended within 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier Gheck only 2 Medical	g Physician: To the best Examiner: On the basis of and manner str	s eneminas	vledge, death ion and/or inve	occurred at estigation, i	t the tim	ne, date and pli pinion, death o	ace, and courred a	due to the cau t the time, dat	use(s) and mi se and place,	enner as st and due to	ated. the cause(	E)
4	To the	Me.	29ti. Signature ang little of certific				290.	License	a number		29	d. Date signe	d (Month, L	Day, Year)	
			MI (li	7 mg			1	29c. License number 29d. Date signed (Month, Day, 1							
		1	50. Name and address of person	who completed cause of d	1 death (Item 23a) (Type, Print)  11 Seffusm BLVD Sm 1 Th3 Sure 6, MB 21783										
H	Sta	te	31 Pate (Ved (Month, Day, Year)	32 Rogistr	The second second	1 1	ism	15	LVD	144	1743/34	ine, ou	0 217	03	
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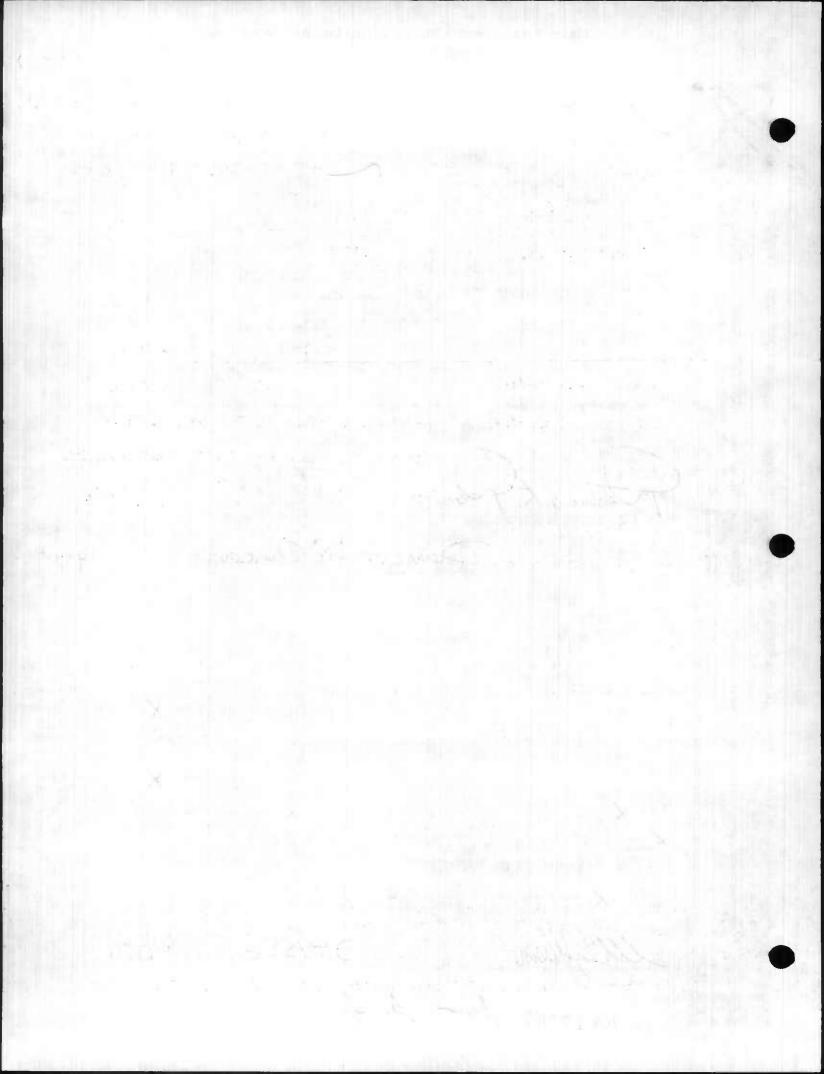
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Lloyd L. Lee	Lloyd L. Leatherman								ilding	18						
9a. Intermant's Name/Relations					18. Mothe	r's Nama	(First, Middle	, Maiden Si	Maiden Sumama)							
						L	ucy J.	Mille	iller							
	ship (Typo, Print) (Friend)						al Routa Number, City or Town, Stata, Zip Code) Rd. Clear Spring, Md. 2172									
20a. Mathod of Disposition  20b. Place of Disposition (Nama of cematary, crematory or other place)								20c. Loca	tion - City or	Town, Stata						
cemetery cremetory or other place)									onvill	o Pa						
/		1100 000														
22. Nama and Addrass of Facility 12525 Bradbury Ave.  Davis Funeral Home Smithsburg, Md. 21783																
3a Part1 Enter the disasse of	r complications that cau	sed the death. F					SIILLIL		Ma. Zi	Approximata						
shock, or haart tailure. List	only ona causa on aac	h lina.	o not ontar the	a moda or oy	mg, 3001 43	0010100	ii toopiiotory e		1	Interval Between						
mmediata Causa (Final																
iseesa or condition asulting in death)	a. ACUTE	BRONCHO	PNEUM	IONIA		-				24 HRS						
	AGDID	Dua to (or as a consequence ot):														
	b. ASPIR	ASPIRATION								1 MONT						
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ause (Disease or Injury	c. Disph			0·						1 MONT						
Cause (Disease or Injury that initiated events rasulting In death) Last  Dua to (or as a consequence of):																
art II. Other eignificant condition	ons contributing to deat	h but not resultin	g in tha underly	ying causa g	iven in Part I.		23b. Did tobacco use contribute to the cause of									
DEMENTIA OF	ALZHEIMER'S	TYPE					10	Yee 2	No 3	robably 4 Uni						
ARTERIOSCLERO	OTIC HEART	DISEASE					24a. Was perfe	an autopsy ormed?		Wara autopsy tindi available prior to completion of caus						
										of death?						
							10	Yas 2 d	No	1 ☐ Yas 2 ☐ No						
5. Was case reterred to medice	1				26. Place	of Deeth	(Check only	ona)								
1 Yes 2 No	Hospital: 1   Inp	atient 2 ER/	Outpatient 3	DOA O	ther: 42 Nu	rsing Hor	ma 5 ☐ Resi	idence 6 [	Other (Spe	cify)						
7. Manner of Death 1 ☑ Natural 5 ☐ Pendir 2 ☐ Accident invasti	Injury				28d. Describe											
2 Decisite S Deutid and be									Number or Re	ıral Routa Number						
9e. Certifiar (Check only one) 1 Certifyir 2 Medical	Examiner: On the basi	s of axamination	ige, deeth occu and/or invastig	urred at tha t gation, in my	lma, data and opinion, deat	d place, a	and due to tha	cause(s) er date and p	nd manner es lace, end dus	stated. to the ceuse(s)						
29b. Signetura end titla of certifiar 29c. Licanse number 29d. Data signed (Monti										h, Day, Year)						
(1)									000							
Carry	roway 1		- 1 PP		35/			JUNE	1/, 1	.999						
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missississississississississississississ	Signature of Funeral Services  Signature of Funeral Services  Sa. Part1. Enter the disaesa, o shock, or haart tailure. List the disaesa or condition sulting in death)  aquentially list conditions, any, leading to immadiate uses as or condition sulting in death)  aquentially list conditions, any, leading to immadiate uses (Disaese or Injury at initiated events sulting in death) Last  at II. Other eignificant conditions are conditionally at initiated events are conditionally at initiated events.  ARTERIOSCLERO  Was case reterred to medice axaminar?  ARTERIOSCLERO  Was case reterred to medice axaminar?  I yes 2 No  Manner of Death  I Natural 5 Pendin invasti invast	Signature of Fundament Service List only one cause on accommediate Causa (Final seesa or condition sulting in death)  ASPIR  accountially list conditions, any, leading to immediate use (Disease or Injury at initiated events sulting in death)  ASPIR  DYSPH  C. Martine of Mart	Signature of Fusional Service Usables  ACUTE BRONCHO Dua to (or as ASPIRATION  Dua to (or as ASPIRATION  Dua to (or as DYSPHAGIA  C. Dua to (or as DYSPHAG	Signature of Funers Service Longee  22. Na  Date  3a. Part 1. Enter the disaasa, or complications that caused the death. Do not enter the shock, or heart tailure. List only one cause on each line.  ACUTE BRONCHO PNEUM.  Due to (or as a consequence and initiate devents sulting in death)  Due to (or as a consequence and initiate devents sulting in death) Last  Due to (or as a consequence and initiate devents sulting in death) Last  Due to (or as a consequence and initiate devents sulting in death) Last  Due to (or as a consequence and initiate devents sulting in death) Last  Due to (or as a consequence and initiate devents are initiated events sulting in death) but not resulting in the under DEMENTIA OF ALZHEIMER'S TYPE  ARTERIOSCLEROTIC HEART DISEASE  Was case reterred to medical axaminar?  Was case reterred to medical examinar?  Was case reterred to medical invastigation of Could not be detarmined at manner of Death invastigation of Could not be detarmined at manner of Death invastigation of Could not be detarmined at manner of Death invastigation of Could not be detarmined at manner of Death invastigation of Could not be detarmined at manner of Death invastigation of Could not be detarmined at manner of Death invastigation of Could not be detarmined at manner of Death invastigation of Could not be detarmined at manner of Death invastigation of Could not be detarmined at manner of Death invastigation of Could not be detarmined at manner of Death invastigation of Could not be detarmined at manner of Death invastigation of Could not be detarmined at manner of Death invastigation of Could not be detarmined at manner of Death invastigation of Could not be detarmined at manner of Death invastigation	Signature of Funeral Service Louises  22. Nama and Addr  Davis Full  23. Part1. Enter the disassa, or complications that caused the death. Do not enter the mode of dy shock, or heart failure. List only one cause on each line.  ACUTE BRONCHO PNEUMONIA  Due to (or as a consequence of):  ASPIRATION  Due to (or as a consequence of):  DYSPHAGIA  Due to (or as a consequence of):  Death of the top of the top of the top of the top	Signature of Funeral Service Life to Specify  Signature of Funeral Service Life to Service Life Life to Service Life to Servic	Signature of Funerial Service Landee  22. Nama and Address of Facility  Davis Funeral Home  23. Part 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac of shock, or heart failure. List only one cause on each line.  ACUTE BRONCHO PNEUMONIA  Busing in death)  Due to (or as a consequence of):  ASPIRATION  Due to (or es a consequence of):  DYSPHAGIA  Due to (or as a c	Signature of Experience   Souther (Specify   20, 99   22. Nama and Addrass of Facility   12525   Smith.	Signature in Figure Service Links  22. Name and Address of Facility  22. Name and Address of Facility  23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line.  23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line.  24. ACUTE BRONCHO PNEUMONIA  Due to (or as a consequence of):  ASPIRATION  Due to (or as a consequence of):  DYSPHAGIA  Due to (or as a consequence of):  DYSPHAGIA  Due to (or as a consequence of):  ARTERIOSCLEROTIC HEART DISEASE  1   Yes   Ye	Signature   Funeral Service   Jake   22. Nama and Address of Facility   125.25 Bradebury   Av.						



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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Medical										June	,	999	7:5	5 P.M
aminer		(If not Institution, g		umber)			4		wn, or Lo	ication of Death		y of Death ederu	ch	
eral	5. Social Security	thampton Number 6	. Sax	7. Age (In yrs	. lest birthday	) If Undar		If Under	24 Hrs.	8. Date of Bir	th .	9 Birthr	laca (Ste	ta or Foreig
ctor	578-24-8	8703	1□M 2√F	77	Yrs.	Months	Days	Hours	Min.	Jan. 2	5,1922	Geo	"Lgia	l
40	Usual Residence	of Decedent		10c. C	ity, Town or L	ocation						1	Od Insida	a City Limit
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leted by Funeral Director	10e, Street and N	Number		1.		10f. Zip					10g. Citizen of		ntry?	
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Funeral	11. Marital Status	s arried 2 Married	Armed F	cedent Ever in U Forces? 2 2 No	J,S. 13.	Was Deced	dent of H cify Cuba	lispanic Ori an, Mexicen	gin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	- 14. Ra	ce - Americen Indian, ack, White, etc.		١,
by F		4 Divorced	If Yes, G Year or	ive		1□ Yes 2	2 X X 10	Specify:			Specif	white		
Completed	(Sr	15. Decedent's pecify only highest	Education	0	16a. Deci	edent's Usua e kind of wor DO NOT us	al Occup	ation during mos	t of work	ina	16b. Kind of B	lusiness/In	dustry	
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000	17. Fathar's Nam	ne (First, Middle, La	est)				J Call		er's Nam	e (First, Middle,				
To Be	Hunt	er Siles	Suddath					R	uth	s Name (First, Middle, Meiden Sumeme) th Donalds on				
	19a. Informant's	Name/Relationship	(Type, Print)								er, City or Town		Code)	
	_	Geiser (I	aughter		6401 Place of Disp			dale	Rd.	Thwwwor	it, Md. 2		Chat	
	20a. Method of D	2 Cremation 3	□Removal from	Audito.	cemetery, cre	emetory or o	ther place		Tuno		20c. Location  Smith			
۵	Donation 1. Signature of													
	1. Signature of Funeral Service Licensee  22. Name and Address of Facility  Davis Funeral Home										Bradburi	1 Ave	62	
	23a. art1. Ente	or the disease, or co	omplications that	Smiths bwrg, de of dying, such as cerdiac or respiratory arrast,					211	Approxi	mate			
n	shock, or heart failure. List only one cause on each line.									or . cop				Dahwaan
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DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Month 1:30 PM ROBERT HILTON 19, LEE JUNE 1999 /Medicai 4e. Fecility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner COLLEGE VIEW NURSING HOME FREDERICK FREDERICK 7. Aga (In yrs. last birthday)

8.5

Yrs.

If Under 1 Year

If Under 24 Hrs.

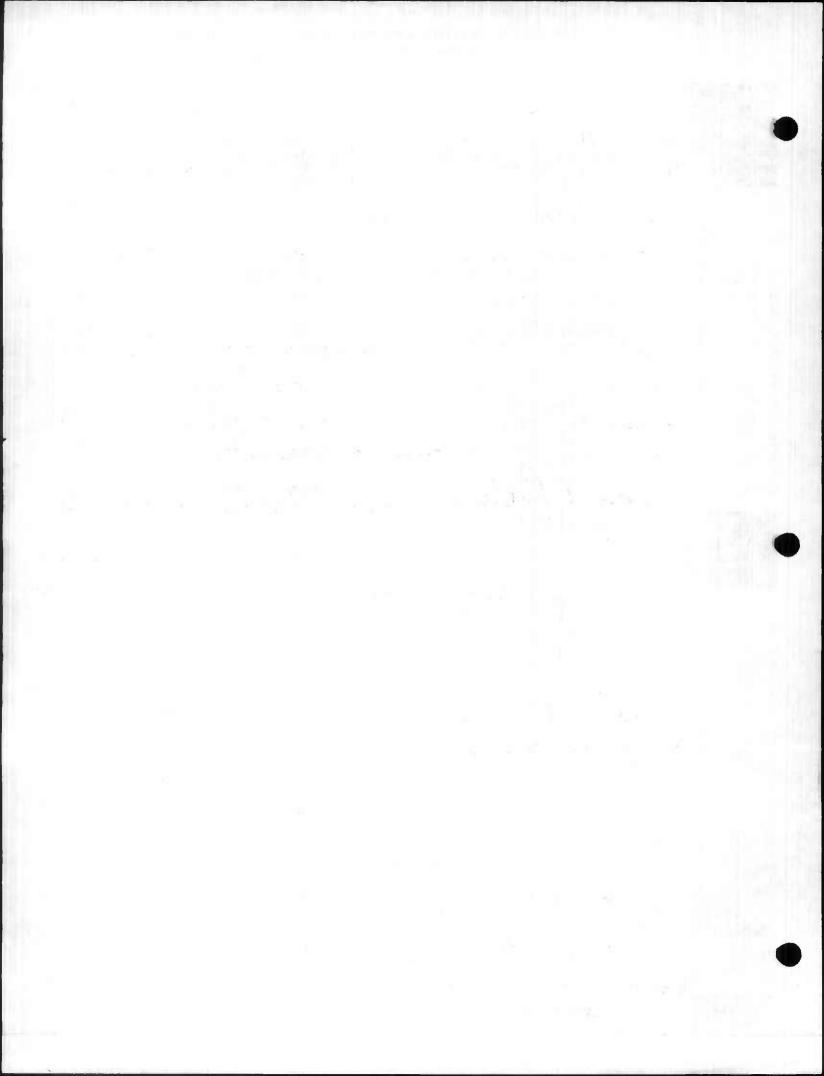
B. Data of Birth

OCT

27, 913 Birthplaca (State or Foreign Country)
 MD **Funeral** 1 M 2□F 219-07-8999 Director Usual Rasidance of Decedant the Maryland 10e State 10b County 10c. City, Town or Location 10d. insida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Mad cal Examiner must be northed at MD. FREDERICK FREDERICK Yas 2 No Director 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 401 CARROLLTON DRIVE 21701 U.S.A. Funeral 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 la merked other than "natural", or Item any injury or other traumatic event 1 Nevar Married 2 Marriad 1 Yes 2 No ↑Yas, Giva Yeer or Datas: Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: BIACK p 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education 16b, Kind of Business/Industry (Specify only highest greda complated) MONT. COUNTY Elamantary/Sacondary (0-12) Collega (1-4or 5+) BUILDING SERVICE SUPER. SCHOOL SYSTEM 12 TH 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) **JOHNSON** GUY HELEN J. GRASON 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) MARIE V. LEE (WIFE) 401 CARROLLTON DR. FREDERICK MD. 21701 20b. Placa of Disposition (Nama of 20a. Mathod of Disposition 20c. Location - City or Town, Stata RESTHAVEN MEM. GAR. 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 23 JUNE 99 21. Signature of Funaral Service License 22. Name and Addrass of Facility GARY L. ROLLINS FUNERAL HOME Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate intervel Batween Onsat and Death **Physician** /Medical Immediata Causa (Final disease or condition rasulting in death) Examiner Sequantially list conditions, if any, laading to Immadiata causa. Enter Underlying Causa (Disaasa or injury that initiated evants rasulting in daath) Last and Dua to (or as a consequance of) physician sthe buriel Box 68760. The law requires that the death certificate be Physician/Medical Dua to (or as a consequanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? P.0. 2 1 Yes 2 No 3 Probably 4 Unknown signed t Records. by 24b. Wara autopsy findings aveilable prior to completion of cause of daath? 24a. Was an autopsy performed? Completed this certificate 1 ☐ Yas 2 ☐ No Division of Vital To the Mospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifics completely filled in by the funeral director, it 25. Was casa rafarred to medical axaminar?
1 ☐ Yas 2 No Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidenca 6 Othar (Specify) 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how Injury occurred Medical Certification: 1 Natural 5 Panding Invastigation 1 ☐ Yas 2 ☐ No 2 Accidant 3 Suicida 6 Could not be 281. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, ferm, straat, fectory, offica building, atc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. 29a, Cartifiar 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licanse number javenue 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) 1475 Towner Halvasan MD Frederick 32. Ragistra, s Signatura 31. Data filed Month, Day State 2 1999 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) June 16, **Physician** 1999 James Wilmer Marshall 12:40 am /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Continuum Care at Sykesville Sykesville Carroll 8. Date of Birth (Month, Day, Year) Sept 4, 1902 If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. iast birthday) Birthplece (State or Foreign Country) 6. Sex **Funeral** 1 M 2 □ F Min Months Deys Hours 213-10-7176 Yrs 96 Director Maryland Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health end Mentel Pyglene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Evaninet must be notified at once. 10d. Inside City Limits 10b County 10c. City. Town or Location 10a State 1 ☐ Yes 2 No Director Baltimore Upperco Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15220 Old Hanover Road 21155 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Mantal Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: White Specify: þ 3 Widowed 4 Divorced Year or Detes: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Eiementary/Secondary (0-12) College (1-4or 5+) G.T. Zepp Co Electrician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) John Kensey Marshall Elsie Cullison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Elizabeth Marshall, wife 15220 Old Hanover Rd, Upperco, Md 21155 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burlal 2 ☐ Cremation 3 ☐ Removal from State Grace Cemetery 6/18 Hampstead, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Licenses Eline Funeral Home tever 934 South Main St, Hampstead, Md 21074 23a. Pert1. Enter the diseese, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel Prostate How Our cer disease or condition resulting in death) Examiner Due to (or as e consequence of) Examine attending physician and for use es the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical that initiated events resulting in death) Last Due to (or as e consequence of): signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ been sig 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? Completed completion of ceuse of death? certificate has birector, page 2 s 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Wes cese referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospitel: Other: 4☐ Norsing Home 5☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No P 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: Naturel 5 Pending investigation death. 1 Yes 2 No 2 ☐ Accident within 24 hours efter death To the Funeral Director: completely filled In by the 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 Suicide Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homleide To the Hospitai Certifying Phyeicfan: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and menner es steled.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. 29e. Certifier edicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signati 29c. License number title of certifie

State Registrar 31. Date filed (Month, Day, Year) **JUN 1 7 1999** 

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32. Registrar's Signature

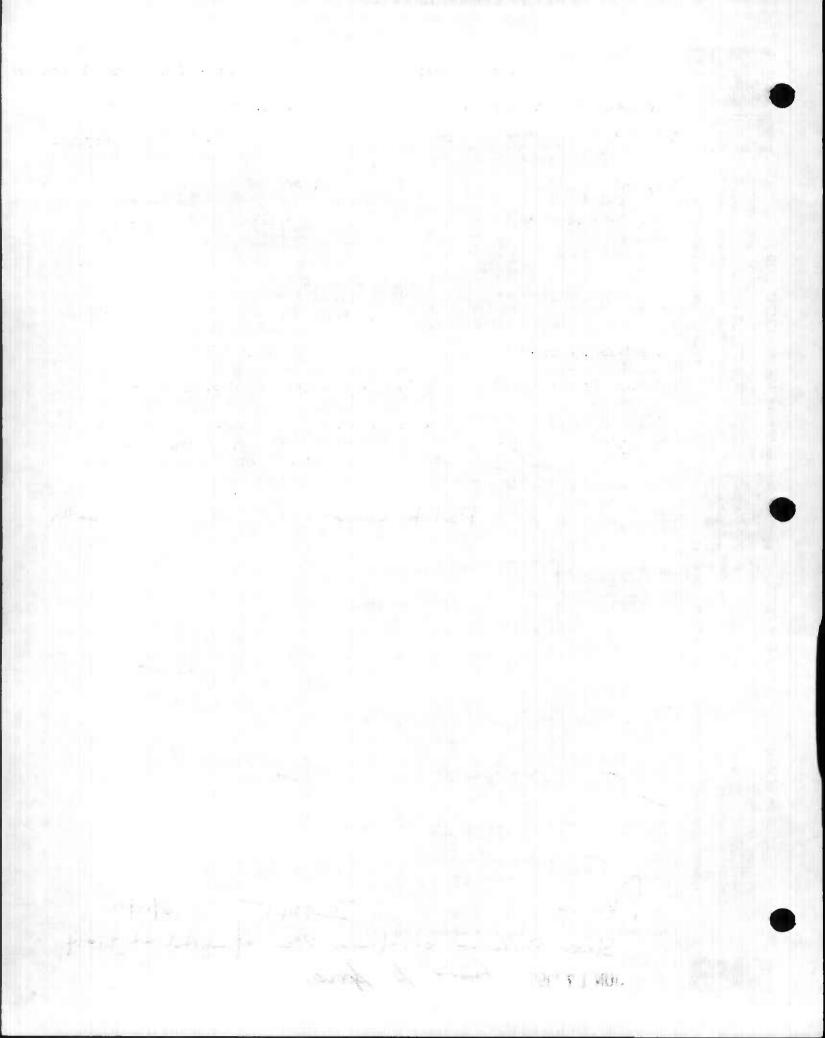
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30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

4. Sparks

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State Registrar 30. Name and a

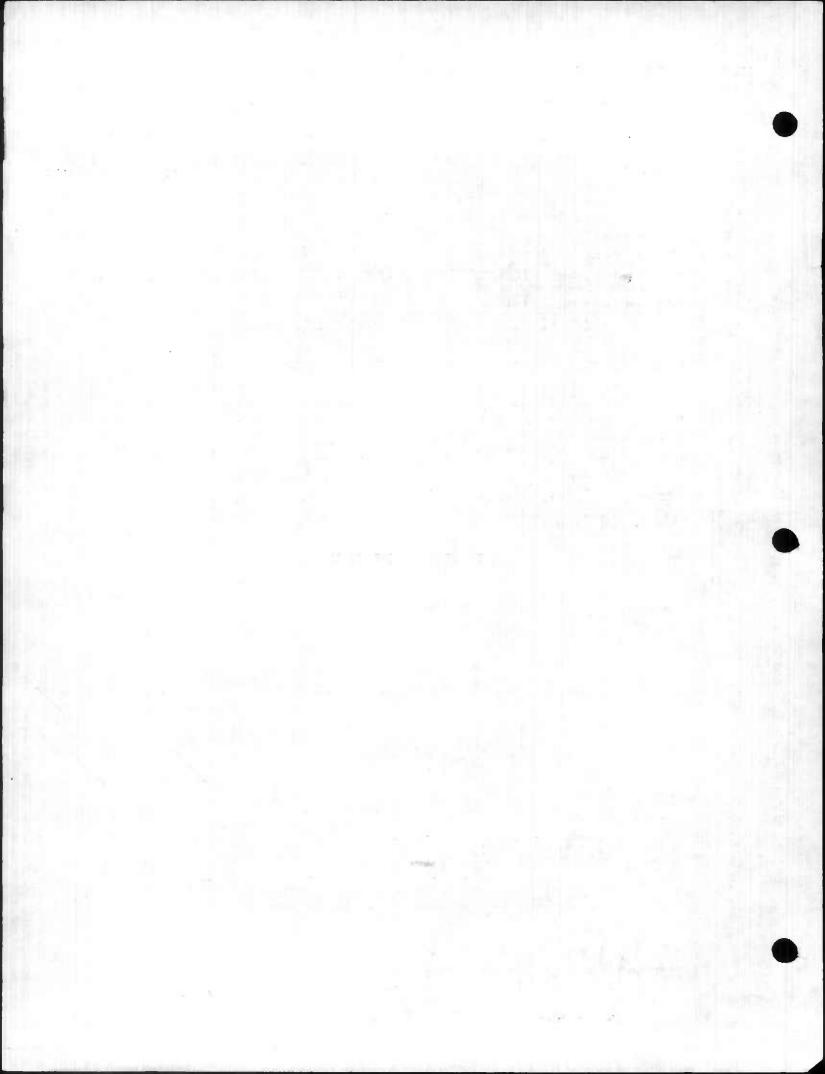
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person who completed cause of death (Item 23a) (Type, Print)

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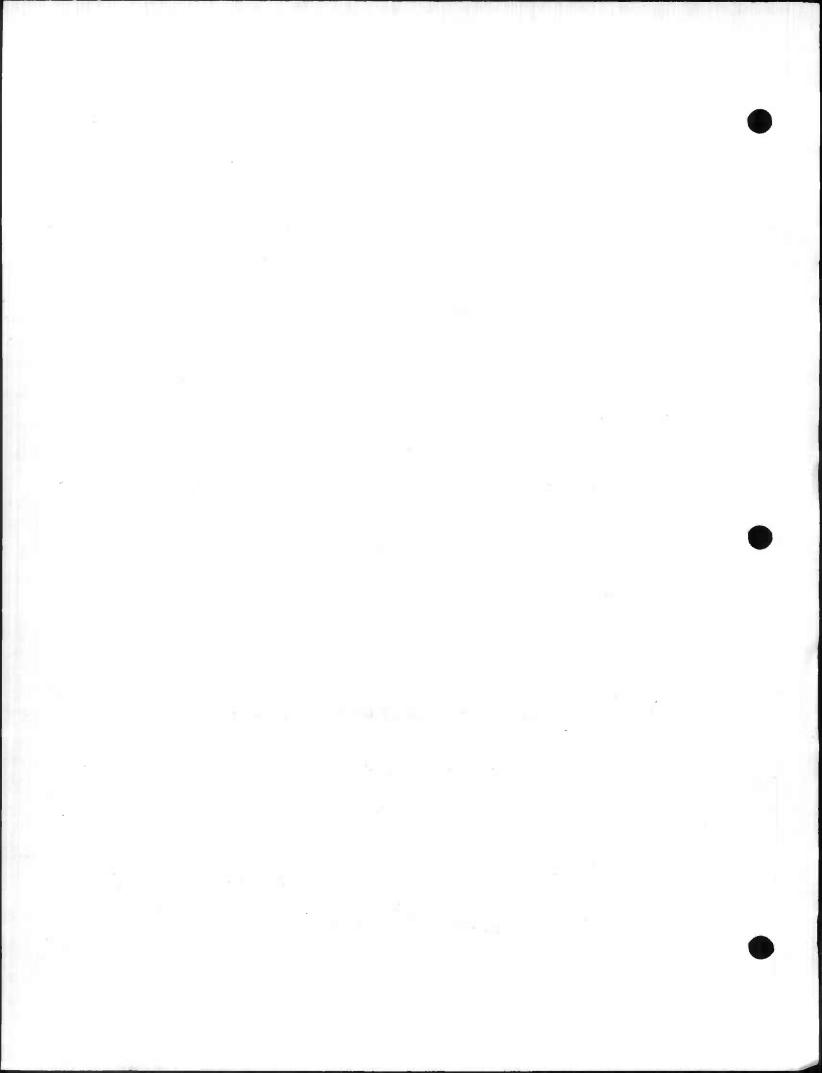


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DIVISION OF VITAL RECORDS,

JUN 1 5 1999

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		Francis Seaton M	cKAY					June 13,	1999	YEAR	LO:04 a.	. м
		4. SOCIAL SECURITY NUMBER	The second second	in yrs. lest		F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		B. BIRTHPL.	ACE (State or Fore	ilgn
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3 should	m	9s. FACILITY NAME (If not institution, give	street and number)		9	b. CITY, TOWN (	OR LOCATION OF D	DEATH	9c. COUN	TY OF DEAT	H	
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an. transii	NER.	20512 Jefferson					2174			USA		
)20 shysici surial-	FUN	11. MARITAL STATUS - 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 X YES	2 N		if yes, sp	ecify Cubsn, Mexic	NIC ORIGIN? (Specify Yes, Puerto Rican, etc.)	s or No-	Black, W	American Indian. /hita, etc.	l <sub>a</sub>
215-0020 attending physician. se as the burial-transit	В	3 ₺ Widowed 4 □ Divorced	IF YES, GIVE WAR OR DA			1 TYES	2 X NO Speci	ify·		Specify	white	
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	오	Douglas McKay -	son					d, Hagerst			1742	
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BALTIMORE er death. Page 6 may the funeral director, pay val.		21. SIGNATURE OF FUNERAL SERVICE LI	CENSUE	-	/	2. NAME AF	ND ADDRESS OF F	ACILITY MINNIC	H FUN	ERAL	HOME	
0 = 0		Local	000kg	nu	ek	415 E	.Wilson	Blvd., Hage	rstow	n, Md	. 21740	)
ca aft		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory errest, shock, or heart fellure. List only one cause on each line.										
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To v red	- Z	DID TOBACCO USE	CONTRIBUTE TO	CAUS	SE OF	DEATH Y	YES I N	0.1		l "	123 27 110	
A 01 E C	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMNER?		0, 10		28. PL	ACE OF DEATH (C					
VIT/ CIAN: The prinficate he State or Item	YSI	1 YES 2 NO	HOSPITAL: 1   Inpatient 2   ER/Outp	etlant 3		OTHER:  Nursing Hom	e 5 Residence	8 Dther (Specify)				
		27. MANNER OF DEATH  1 Netural 5 Pending	(Month, Day, Near)		28b. TIME (	WO WO	RK?	28d. DESCRIBE HOW	INJURY OCCU	JREO/	1	
ON OF DING PHYSI After this o death with s marked,	BY	2 Accident Investigation	06/13/19	411	1005	7.41		Shot SE	st in	hee	d	,
VISION ATTENDING ECTOR: After s after death	ED	3 Suicide 8 Could not be determined	28s. PLACE OF INJURY building, stc. (Spec	- At non	ne, term, atre	el, tactory, offic	•	281. LOCATION (Street City or Town, State	and Number o	r Rurai Rout	Number 1405	lan
DIVISION DR ATTENDING DIRECTOR: After hours after death item 28 is man		29s. CERTIFIER		/ \	4016	_		120512	Jekels	or 1)1	W in	2
E SE E	COMPLET	(Check only CEHTIFYING PHYS	ER: On the best of my knowledge.									
THE HOSPITAL THE FUNERAL filed within 72		290. SIGNAZUNE AND TIXE COLUMNIE	ER: On the basis ot examination	· arra/Of II	vvenganon,	m my opinion, d						led.
THE SEE	BE	1/1/11/15					29c. LICENSE NU	COY	29d, DATE	SIGNED (M	onth Day, Year)	
663₹	2	30. NAME AND ADDRESS OF PERSON WI	10 COMPLETED CAUSE OF DE	ATM //TEM	273 / Toron D	elme)	116	xclo		211	1/1/	



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

# STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First	Middle, Lest)			0	10/11				2. DATE OF DEATH			3. TIME OF OEATH
Gloria Jean MARTIN June 12, 1999 YEAR 9:10									9.10 0.				
	4. SOCIAL SECURITY NUME	BER	5. SEX		s. last birthday)	IF UNDE	R 1 YEAR	IF UNDE	R 24 HRS.	7. DATE OF BIRTH	1))		PLACE (State or Foreign
	215-44-9789		1 M 2 X F	,	55 YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Your) March 30,	10/./.	Country	
	9n. FACILITY NAME (If not in	astitution, give st	reet and number)			9b. CIT	Y, TOWN (	OR LOCATI	ION OF DE			JNTY OF DE	-
<u>۳</u>	19826 Benni	e Driv	e			1	Hage	rsto	wn			shing	
5	RESIDENCE OF DEC					<u> </u>							
DIRECTOR	10a. STATE	10b. COUNTY			I	TY, TOWN							10d. INSIDE CITY LIMITS?
	Maryland		ington		Ha	igers	towr	1					1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 104 East F		treet				101	ZIP COD	217	7/10			THAT COUNTRY?
Ä		1100									U.S.A.		
3	11. MARITAL STATUS 1 Never Married 2	Married	12. WAS DECEDEN	YES 2	X NO	13.	WAS OED	ENOENT (	OF HISPAN an, Maxicar	IC ORIGIN? (Specify Yes	or No-		- American Indian, , White, atc.
B	3 Widowed 4 🖾 Divo		IF YES, GIVE	WAR OR DATES	S		1 TYES	2 🔀 NO	Specify	Specify:			white
	15. DEC	EDENT'S EDUC	CATION	184	n. DECEDENT'S	S USUAL C	CCUPATIO	ON		16b, KIND OF BUS	SINESS/IN	DUSTRY	
	(Specify onl	y highest grade	College (1-4 or 5		(Give kind of life, Do NOT (	work done ise retired.)	during mo	st of worki	ing				
COMPLETED	0-12		2	"	ele	c. er	ngin	eer		powe	r co	mpany	
ŏ	17. FATHER'S NAME (First, M			_				18. MOT	HER'S NA	ME (First, Middle, Maiden			
BE (			Martin,	Sr.						Esther	K. D	iehl	
9a. INFORMANT'S NAME (Type/Print) Mrs. Esther Winghart/mother  19b. Mailling address (Street and Number or Rural Route Number, City or Town, State, 19826 Bennie Drive, Hagerstown, Ma										d 21740			
	17020 Bennie Brive, nagerstown, maryland												
	1 Burial 2 Crematic	n 3 🗌 Rame	oval from Stata	cemeter Ha	y, cremetory or	other place	rema	torv	7				n, Maryland
	21. SIGNATURE OF FUNERA		ENSEE		7				SS OF FAC				al Home
	10 Ca	set	MA	in	w	14	15 E	ast 1	Wilso	on Blvd.,	Hage	rstow	m, Maryland 21740
	23. PART I. Enter the d	iseases, or c	omplications the	t caused th	a daath. Do	not ente	r tha mo	da of dy	ring, such	ss cardiac or respi	retory si	rrest,	Approximate
	shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final  Onset and Desth												
	disesse or condition	<b>→</b>		2 VO	Mud	n	CC	M	CU	7			28 48 WW
1			DUE TO	(DR AS A CO	NSEOUENCE (	OF):							0
NO	Sequentially list condit		DUE TO	(OB 45 4 CO)	NSEQUENCE (	NF)							
CERTIFICATION	if sny, lesding to imme cause. Enter UNDERLY		DOE 10	(OR AS A CO	NSECUENCE (	ле):							
ピ	CAUSE (Disease or Injuthat Initiated avants	iry	DUE TO	(OR AS A CO	NSEQUENCE (	OF):							
E	resulting in death) LAS	T	1.										
	PART II. Other significa	at condition	a anatolhutlan ta	death but		I. M							
EDICAL	1 1 1		1 '	J.	1 1	. 11	~ I	g cause		PERFOR		24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
ă		SOU		2	DOU	16 1 (	rai	NOI	$M_{0}$	1 TYES 2	No		OF DEATH?
Σ		otho	4							<b>5</b> /			1 TES 2 NO
PHYSICIAN:	DID TOBACC 25. WAS CASE REFERRED TO		CONTRIBUT	E TO C	AUSE O	F DEA		ES [	NC				
2	EXAMINER?	O MEDICAL	HOSPITAL:			OTHE		1		ick only one)			
Ϋ́	1 YES 2 NO		1 Inpetiant 2		28b. Ti!		rsing Hom 26c. INJ	$\rightarrow$	asidenca	8 Other (Specify) 28d. DESCRIBE HOW II		NAME OF THE PARTY	
	Netural 5	Pending	(Month, L		200. IN	JURY		PIK?	ND	280. DESCRIBE HOW I	NJURY OC	CURED	
B	2 Sutelde	Investigation	28a. PLACE (	F INJURY — /	At home, ferm,	streat, fac				28f. LOCATION (Street a	and Numbe	v ov Rumi B	num Mumbar
E		Could not be detarmined	building,	atc. (Specify)			,,			City or Town, State)		or ribrer ri	oute rumon,
29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.													
COMPLETED										to the cause(a) and mar time, data and placa, an			and manner as stated.
	29b. SIGNATURE AND TITLE				0				-				
M) D1/1/73 1 6/1/1/90								11, 90					
2	30. NAME AND ADDRESS OF	F PERSON WHO	COMPLETED CALL	SE OF DEATH	(ITEM 27) (Spo	e. Prijnt)			177			0/1	7///
	363 S.	Clove	and 1	AVE	Su	+	20	1:1	Hac	ver stou	um	MÍ	D 2174 0
			22. PACOUSTRY	SIGNATU		Too	1	, /		0000000	50 //	-4	0.1-1.0
	JUN 1 5 1999 Parks												



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death **Physician** 12<sup>y</sup> June 1999 Cristina Leigh Miller 7:40 PM /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Nama (If not institution, giva street and number) Examiner Washington County Hospital Hagerstown Washington County If Under 1 Yaar | If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Deta of Birth (Month, Day, Yaar) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours Min 1 M 2 XF 26 Yrs. 216-04-4420 Dec. 21, 1972 Director Maryland Usuai Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Haelth and Mentel Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic exceptions. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 DXNo Maryland Washington County Hagerstown Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18445 Woodside Drive 21740 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-tf Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indien. 11. Merital Status Bleck, White, etc. 1 ☐ Yes 2 ▼No If Yes, Give Year or Datas: 1 ☐ Never Merried 2 ☐ Married White 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorcad Completed 15. Decedent's Education (Specify only highest grada completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work done during most of working life. DO NOT use ratired) Eiementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fathar's Neme (First, Middla, Last) 18. Mother's Nema (First, Middla, Maiden Surname) Valter Valenca Linda Leigh Schmidt 19a. Informent's Name/Raiationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda L. Valenca/Mother 17419 General Lee Drive, Sharpsburg, Maryland 21782 20a. Mathod of Disposition 20b. Plece of Disposition (Name of cemetary, cramatory or other place) 20c. Location - City or Town, Stete 1 Buriei 2 Cremetion 3 Removel from Stete 4 Donetlon 5 Other (Specify) June 15 Hagerstown, Maryland Cedar Lawn Memorial Park 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 ceuclos A. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or haert lafture. List only one cause on each line. Approximata Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition rasulting in daeth) /Medical 6 months Lung Metastasis Examiner Dua to (or as a consequence of): Physician/Medical Examiner Tonque Carcinoma 19 months that the death cartificete be axecuted physician and tha burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disaasa or injury that Initiated evants resulting in death) Lest Dua to (or as a consequence of) Box 68760 Due to (or es e consequenca of): 80 usa for ed by the e 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 20 No 3 ☐ Probably 4 ☐ Unknown signed t Division of Vital Records, by 24b. Were eutopsy findings aveilable prior to 24a. Was an autopsy parformed? Completed Deen completion of cause of daath? paga 2 s has 1 Yas 1 ☐ Yas 2 ☐ No cartificata Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) examiner? 1□ Yes 2No Hospital: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Sinpatient 2 3 DOA 2 ER/Outpatient After this 28e. Dete of Injury (Month, Day Year) 27. Manner of Dec 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 De Naturel 2 Accident 5 Pending invastigation 1 TYes 2 No ofter daath Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Pleca of injury - At home, ferm, street, fectory, office building, etc. (Specify) à 4 Homicida 6 Hospital 24 hours edical Certifying Physician: To the best of my knowledge, death occurred et tha time, date end pleca, end due to tha causa(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred et the time, data and place, and due to the ceuse(s) and mannar statad. 29a. Cartifier within 24 hor To the Fune complately fi (Check only one)

State Registrar

H. Hamdan, MD, 363 S. Cleveland Avenue, Hagerstown, Maryland 21740 31. Dete filed (Month, Day, Yaar) 1999

30. Neme and address of person who completed cause of daeth (Item 23a) (Type, Print)

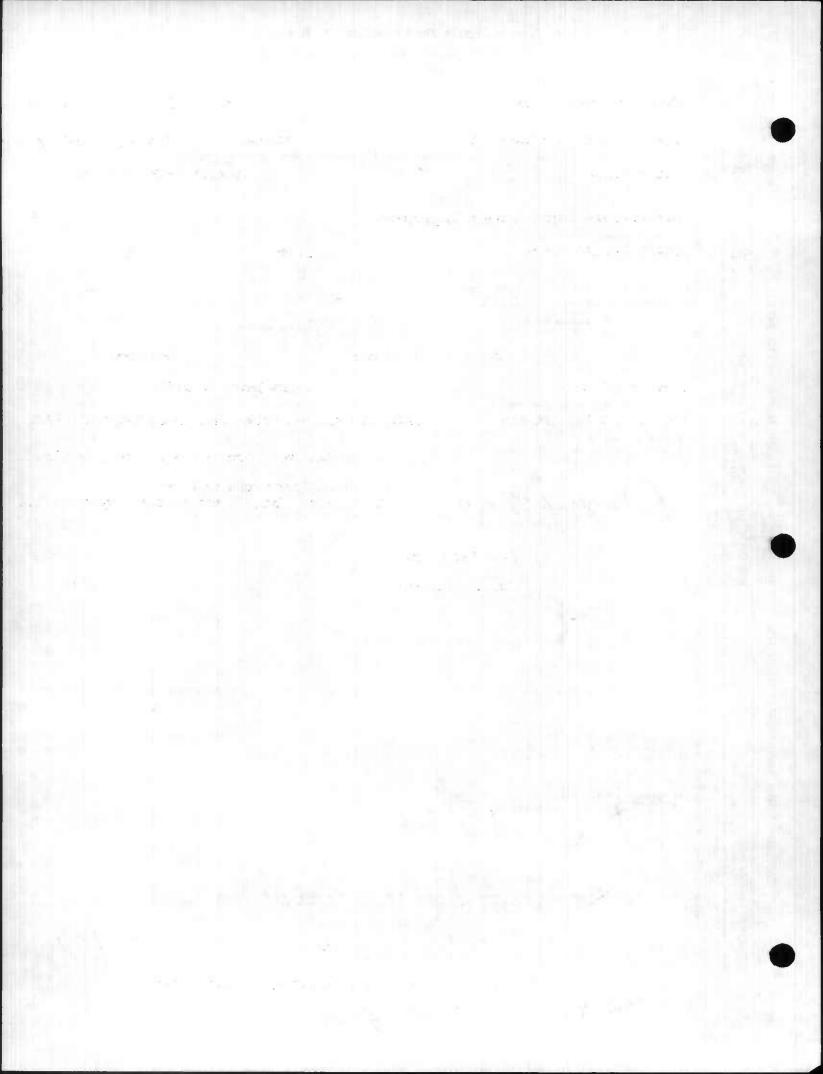
29b. Signeture end title of certifiar

32 Registrer's Signeture

29c. Licansa number

D46473

29d. Date signed (Month, Day, Year)



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middla, Last) 3. Time of Death Month 1999 June 16, 7:45 P.M. Charles Otis Masemore 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death 46 Blue Ridge Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Thurmont Frederick Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 X M 2 □ F Yrs. Nov 16,1922 76 219-12-0096 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No THurmont Maryland Frederick 10e. Sfreef and Number 10f. Zlp Code 10g. Citizen of What Country? 21788 46 Blue Ridge Avenue States United 12. Was Decedent Ever In U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian 11. Marital Status

1 ☐ Yes 2 ☐ No Specify:

16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired)

Millwright

20b. Place of Disposition (Neme of cematery, crematory or other place)

Blue Ridge Cemetery

Specify:

18. Mother's Neme (First, Middle, Maidan Surnama)

22. Name end Address of Facility Stauffer Funeral Homes, P.A.

Cameron

Mamie M.

46 Blue Ridge Ave., Thurmont, MD

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda)

16b. Kind of Business/Industry

21788

6/19/99 Thurmont, Maryland

20c. Location - City or Town, State

white

MD 21701

Federal Government

1 XYes 2 No 1943
If Yes, Give
Year or Dates: — 1945

College (1-4or 5+)

with the Merylenc Itsm 27 is marked other than "natural", or Itema 23e or 28a-f show other trsumatic svent, the Medical Examiner must be notified at permit. Pages 1 and 2 should be filed within 72 hours efter death a Department of Health and Mentel Hygiene. Important: If itsm 27 is marked other than "natural", or items 29a any injury or other traumatic event, the Medical Examiner must once. Baltimore, Maryland 21215-0020

**Physician** 

/Medical

Examiner

10e. State

1 Never Married 2 Married

15. Decedent's Education (Specify only highest grade completed)

3 Widowed 4 Divorced

Elementary/Secondary (0-12) 8th

20a. Method of Disposition

17. Father's Neme (First, Middla, Last)

Charles V. Masemore

19a. fnformant's Name/Reletionship (Type, Print)

Ruth T. Masemore wife

4 ☐ Donation 5 ☐ Other (Specify)

21. Signeture of Funeral Service Licenses

1 ☒ Buriai 2 ☐ Cremetion 3 ☐ Removal from Stete

30. Neme and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

BARAKA

012

32. Registrar Signature

Directo

Funeral

ģ

Completed

**Funeral** 

**Director** 

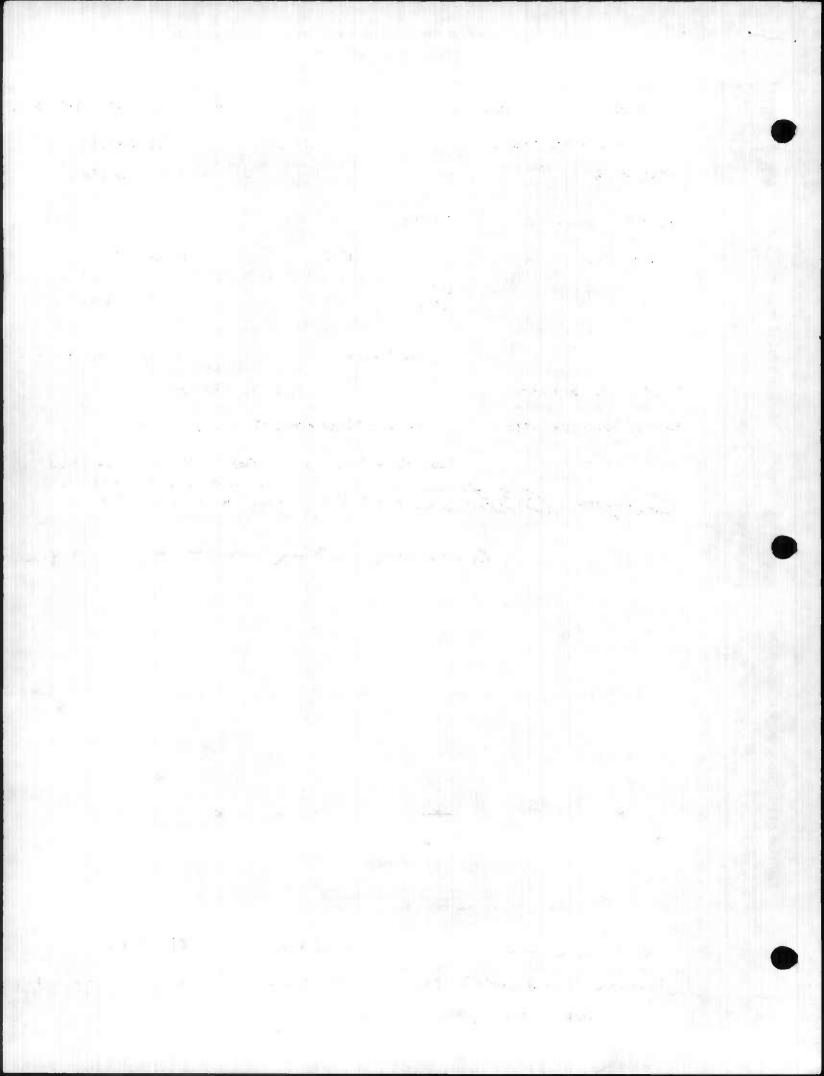
Phy /M Exa

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Division of Vital Records, P.O. Box 68760,

23a. Part. Enturine disease, or com shock, or near failure. List only	plicetions thet caused the dea one ceuse on each line.	th. Do not enter the	mode o	f dying, such as cardia	ac or re	spiretory errest,	Inte	roximate rvai Betweer set and Death
Immediate Cause (Final disease or condition resulting in death)	· Coro	nowy	a	Jen	بكر	ins	( )	4 ye
	Due to (	or es a consequence	of):					
Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying	b Due to (	or as a consequence	a of):					
Ceuse (Disease or Injury that initiated events resulting in death) Last	C. Due to (	or as a consequence	of):				i	
Part II. Other significant conditions of	contributing to death but not re-	sulting In the underly	ing cau	se given In Part I.		23b. Dfd tobacco use c	ontribute to the	cause of de
						1 Yes 2 No	3 Probably	4 Unki
						24e. Wes an eutopsy performed?		ie prior to tion of cause
						1 ☐ Yes 2 🗷 No	1 □ Ye	s 2 No
25. Was case referred to medicel examiner?				1	eath (C	Check only ona)		
1 Yes 2 No	Hospitai: 1 ☐ Inpatient 25	Con Outpetient 3[	DOA	Other: 4 Nursing	Home	5€ Residence 6 □0	ther (Specify)	
27. Manner of Death  1 Natural 5 Pending  2 Accident investigation		28b. Time of Injury		Injury at Work? 1 Yes 2 No	28d	. Describe how injury occur	urred	
3 Suicide 6 Could not be determined	28e. Placa of Injury - Af t building, etc. (Spec	nome, farm, streef, fe	ectory, c	ffice	28f.	Location (Street and Num City or Town, Stata)	nber or Rural Ro	uta Number,
	nysician: To the best of my kniner: On the basis of examinend menner stafed.							
29b. Signeture end title of certifier			29c. L	icense number		29d. Date sign	ed (Month, Day,	Year)
h , , /	- Contraction		-	2164 8		( , -		

Registrar



### Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** 20, 6:22 PM 1999 June JULIET MOORE NOTTINGHAM /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Frederick Homewood Retirement Center Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 XF Yrs. **Director** Sept. 15, 1911 Japan 87 217-09-0281
Usual Residence of Decedent with the Maryland permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylan Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any higher or other traumatic event, the Med cal Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. Count 1 Yes 2 No Maryland Frederick Directo Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 31 West Patrick Street U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes Z☐ No If Yes, Give Year or Detes: 14. Race - American indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stafus 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify þ Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) Secretary Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Nancy Parsons Garland P. Moore 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. Kendall Nottingham (Son) 393 Charlton Ave. South Orange, NJ 07079 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dafe 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 6/21/99 Smithsburg, Maryland Smithsburg Crematory 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 enter the mode of dyling, such as cerdiac or respiratory arresf. Approximate Interval Between Onset and Death The most Po not enter **Physician** ve Heart Failure Immediate Cause (Final disease or condition resulting in death) /Medical 1 monit Examiner Due to (or as a consequence of) Examiner physician and the buriel-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lasf Due to (or as a consequence of) P.O. Box 68760. Physician/Medical Due to (or as a consequence of): 88 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 Sarcoma 3 ☐ Probably 4 ☐ Unknown signed by Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? page 2 should Completed certificate has 2 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was cese referred to medicel exeminer? Be 26. Plece of Deeth (Check only one) Hospitai: 1 ☐ Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending investigation efter death. 2 🗆 No 1 ☐ Yes 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only within 2 To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 009680 11.0 -16-30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print) 300 West Ninth Street, Frederick, Maryland 21701 Austin Pearre, Jr., MD 31. Date filed (Month, Day, Year) 2 32. Registrage Signature State 1999

**DHMH 16 Rev 6/95** 

Registrar

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### Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dala of Death 3. Tima of Death Month 18:15 4e Facility Nama (If not institution, give street and number) CARROLL COUNTY HOSPITAL 4b. City, Town, or Location of Death c. County of Death WESTMINSTER CARROLL | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) | 1 / 11 / 1917 If Under 1 Yaar 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1□M 2/2 F 82 401-26-7963 INDIÁNA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 412 E. MAIN ST. 21157 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Black White etc. 1 Never Married 2 Married 1 Yas 2X No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TEACHER'S AIDE EDUCATION 12 17. Father's Name (First, Middle, Last) 18. Mothar's Neme (First, Middle, Maiden Sumame) WILLARD JESSE RIDDLE NORA ELIZABETH WASH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) JAMES E. PARKER - SON 412 E. MAIN ST., WESTMINSTER, MD. 21157 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 N Burial 2 ☐ Cremetion 3 ☐ Removal from State MEADOW BRANCH CEM. 6/17/99 WESTMINSTER, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximata Interval Between Onset and Death Immediata Causa (Finel disease or condition resulting in death) Hy poxem: a Dua to (or as a consequence of): neymonio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as e consequence of): Due to (or as a consequence of)

Physician /Medical Examiner

Physician

/Medical

Examiner

**Funeral** 

Director

'naturel', or items 23s or 28s-f show dical Examiner must be notified at

pernit. Peges 1 and 2 should be filed within 72 hours effer deeth v Department of Heelth and Mental Hyglene. Importants if item 27 is marked other than "naturel", or Items 234 eny Injury or other traumstic event, the Heddel Examinar mass

altimore, Maryland 21215-0020

Director

Funeral

Completed

Be

MD.

Physician/Medical Examiner Hospital or Attending Physicien: The lew requires that the deeth certificate be executed Division of Vital Records, P.O. Box 68760, signed by the e P Completed Be Certification: To this Affer efter deet! Director:

	d				
and 11. Other significant conditions of	2) 2 2 3 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3			23b. Did tobacco use co	ntribute to the cause of death?
V			- 1	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
				1 Yas 2 No	1 Yes 2 No
5. Was case refarred to medical			26. Place of De	eath (Check only one)	
axaminer?	Hospital: 1 Hopatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Homa 5 ☐ Residence 6 ☐ Oth	er (Specify)
7. Manner of Death  1) Natural 5 Pending 2 Accident investigation		28b. Tima of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	red
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, atc. (Speci	oma, farm, street, fectory)	ory, office	28f. Location (Street and Numb City or Town, Stete)	per or Rural Route Number,

12 Certifying Physician: To the best of my knowledge, death occurred et the tima, data and place, and due to tha cause(s) and manner as stated. 2 Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner staled. 29c. License number

D 52479

29d. Data signed (Month, Day, Year)

13,19

June

State Registrar

filled in by

edical

29a. Certifie

29b. Signature and titla of certified

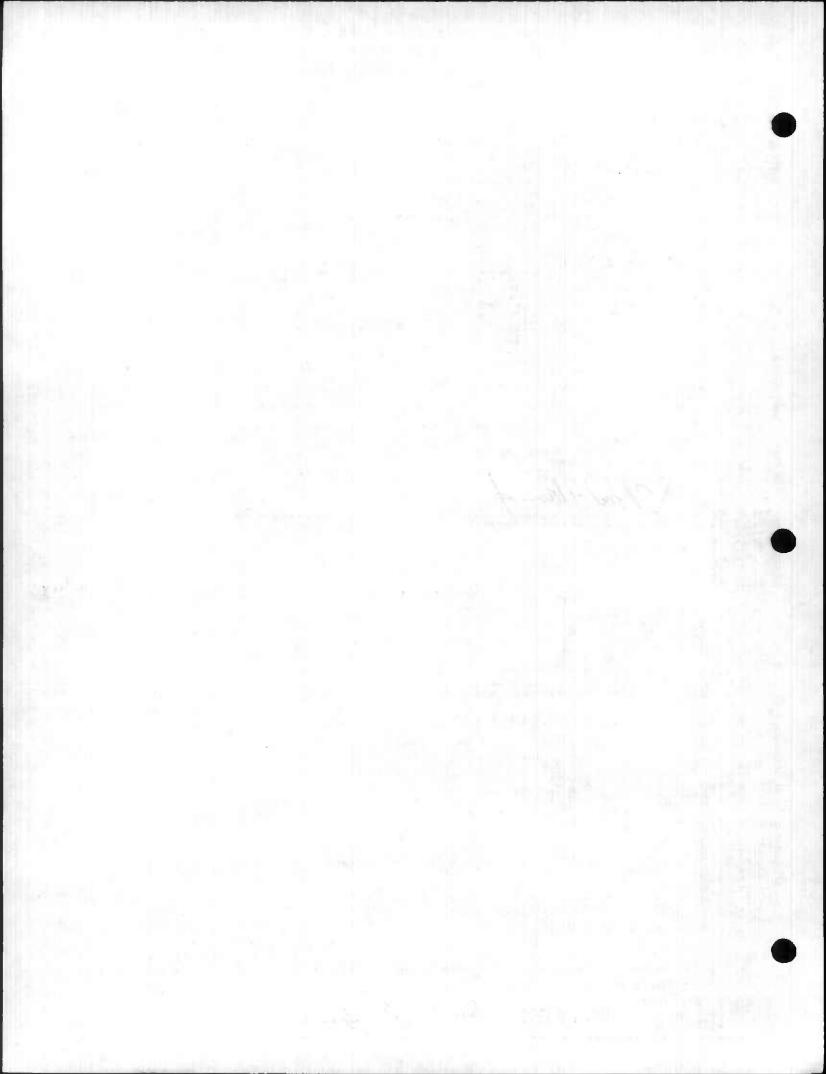
31. Data filed (Month, Day, Year)

To the Hospital of within 24 hours of To the Funeral Discompletely filled.

Hospital at 200 memoria Avenue 32. Registrar's Signature JUN 1 6 1999

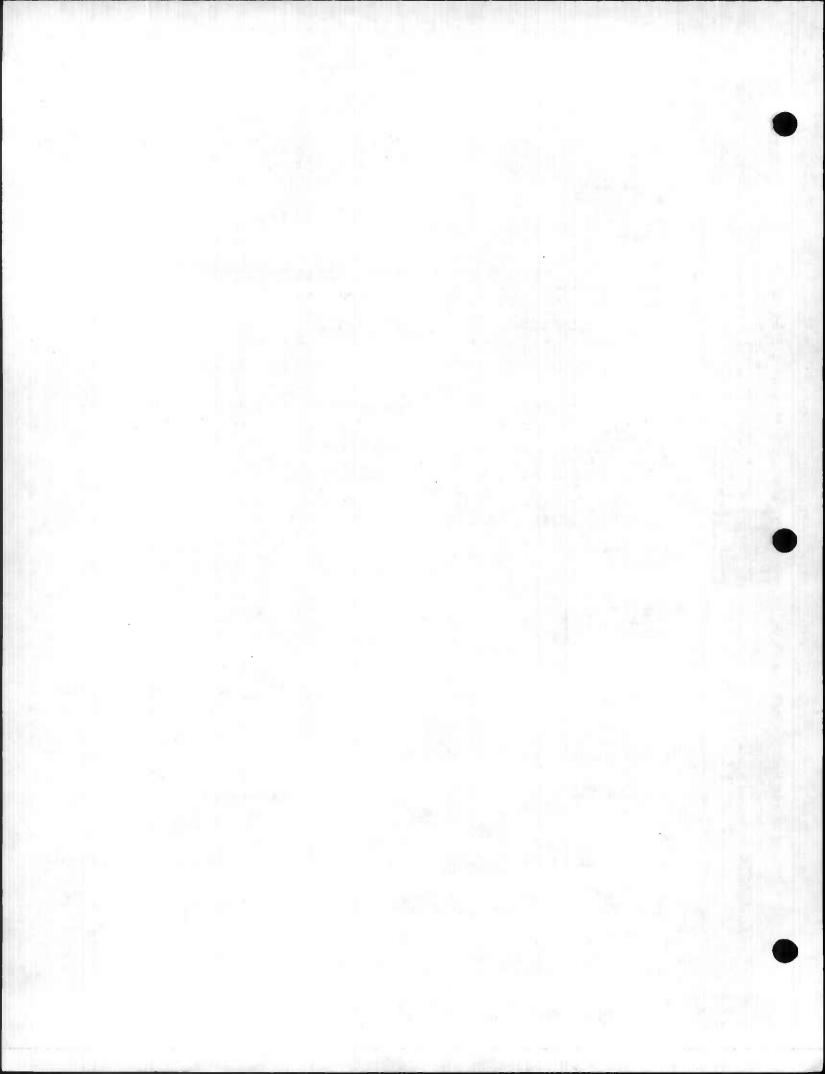
Westminster, MO 21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) L(SA Kim, MD. at Carroll County General



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

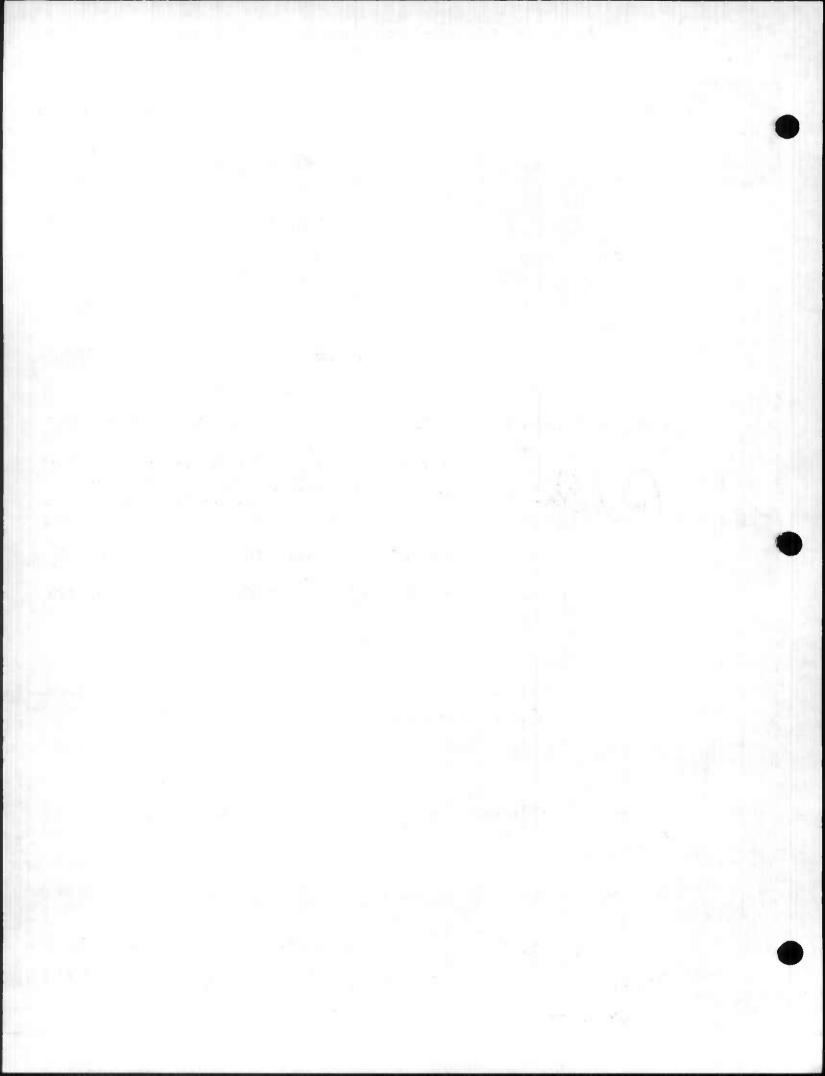
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Year **Physician** PATRICIA Ann POFFENBERGER 16:37 06 99 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner MARYLAND OF - SHOCK TRAUMA BALTIMORE Baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 XF 42 July 14, 1956 West Virginia 220-64-7129 Director **Usual Residence of Decedent** the Manyland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglens. Important: If item 27 is marked other than "natural", or thems 23s or 28s-f show shiplury or other traumatic avent, the Media. Examina must be notified at page. 10a State 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Director Maryland Washington Sharpsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17618 Millers Sawmill Road 21782 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 N Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence 12 Years 18. Mother's Name (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) Anne Allen James Kirby 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert E. Poffenberger/Husband 17618 Millers Sawmill Road, Sharpsburg, MD 20b. Plece of Disposition (Neme of cematary, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stele 4 ☐ Donation 5 ☐ Other (Specify) Mt. View Cemetery 06/21/1999 Sharpsburg, Maryland 21. Signature of Funeral Service Licensee P. St Danjur, 74 22. Neme end Address of Facility 7606 Old National Pike Bast Funeral Home Boonsboro, Maryland Steven Danfelt, Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Physician Immediata Cause (Final disease or condition resulting in death) /Medical SEPSIS Examiner Due to (or as e consequence of): Physician/Medical Examiner FUNDOPLICATION physician end the burial-transit the deeth certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of): Box 68760. that initiated events resulting in death) Last Due to (or es a consequence of): US0 88 1 P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yea 2 PNo 3 | Probably 4 | Unknown The law requires that Records. à 24b. Wera autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 1 Yea 2 No 1 ☐ Yes 2 ☐ No certificata of Vital al or Attending Physician: The star death.
I Director: After this certificated in by the funeral director, p. 25. Was case referred to medical 8 26. Place of Death (Check only ona) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpetient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Illed in by 4 Homicide To the Hospital of within 24 hours of To the Funeral D completely filled I 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as atated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(a) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6-17-79 Critical Care 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TANDON S. GREENE STREET BALTIMORE 32. Registrar'a Signeture 31. Date filed (Month, Day, Year) State **JUN 21** 1999 Registrar



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

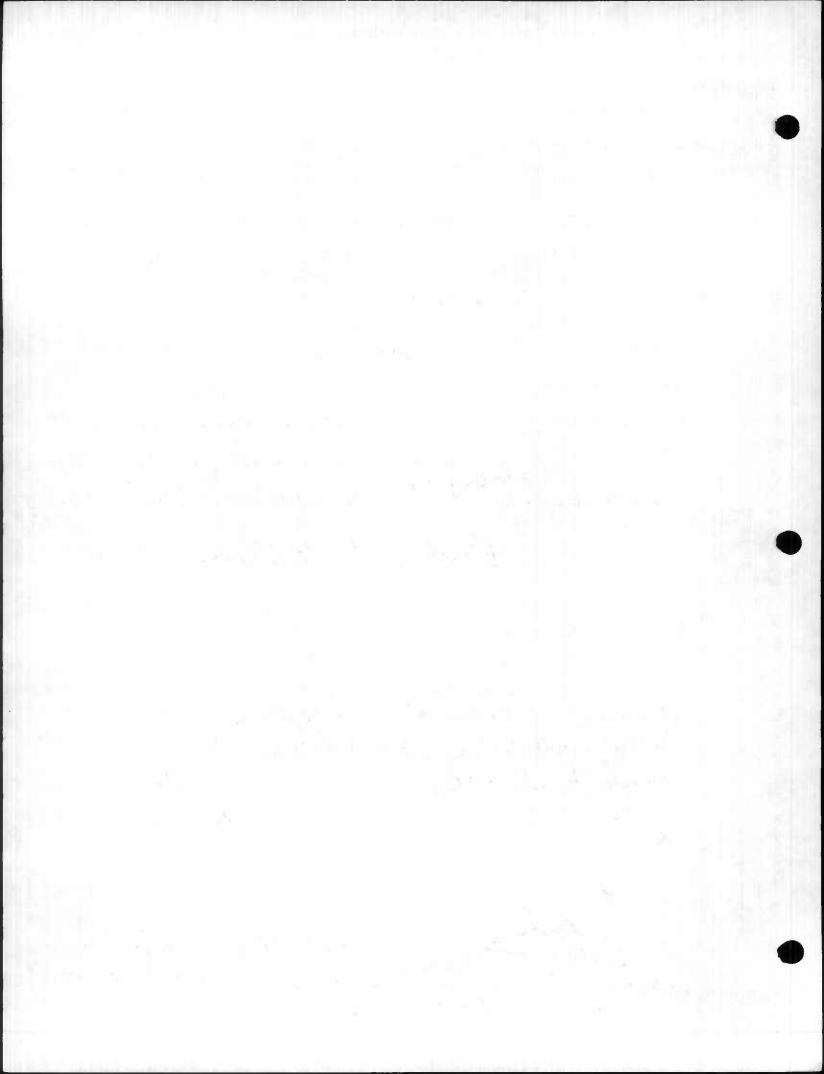
State of Maryland / Department of Health and Mental Hygiene

					Certific	ate of	Death		Reg. No.	) (	21123		
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Physic /Med		CLAUDE FRANKLIN P.	ALMER					JUNE 13	1999	Yeer	10:30 P.M		
Exam		4a. Facility Name (If not institution, git	re street and number)				4b. City, Town, o	Locetion of Death		of Deeth			
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Funera		Designation of the second seco	Sex 7. Age (//	n yrs. last bin	thday) If Ur Mont	nder 1 Year	If Under 24 Hr	s. 8. Dete of Birti	3				
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nytan how	_	10a. State 10b. County	10	Oc. City, Town	n or Location					1	10d. fnside City Limits		
e Ma	cto	MARYLAND WASH	INGTON				BOONSBOR	C			1 ☐ Yes 2 🖾 No		
or 2	Director	10e. Street and Number			10f.	Zip Code			10g. Citizen of V	Vhat Cour	ntry?		
23a		7903 MAPLEVILLE	ROAD				21713			U.S.A	Α.		
er de	Funerai	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U,S.	13. Was De	ecedent of I	Hispanic Origin? ( an, Mexicen, Pue	Specify Yes or No- rto Rican, etc.)	14. Rec	e - Americ	can Indian,		
be filed within 72 hours efter death with the Maryland tiel Hygiene.  Identify then "natural", or items 23a or 28a-f show event, the Marical Examinar must be notified at	þ	1 ☐ Never Married 2 ☒ Merrled 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔯 No if Yes, Give Year or Dates:				Specify:		Specify	<i>'</i> :	HITE		
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thin thin	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NO	T use retire	during most of wi	orking					
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d 2 should be filed that and Mentel Hygin 7 Is marked other traumatic event, I	Be	17. Father's Name (First, Middle, Last	)				18. Mother's Na	ame (First, Middle, Maiden Surneme)					
should be nd Mentel marked o	2	Gaulesba Blaine H					Beulah	Mae Beac	hley				
0 0 0 0		19a. informant's Name/Relationship (						Ru <i>ral Route N</i> umbe					
C = 01 .	1	GLENDORA V. PALMI						BOONSBO	RO, MAR	YLANI	D 21713		
Peges 1 nent of H int: If ite		20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of cemeter	Disposition ( y, crematory	Name of or other pla	ice)	Date	20c. Location -	City or To	own, State		
then of Hee tant: If item 2		4 □ Donetion 5 □ Other (Special		BOONS	BORO C	EMETE	RY	6/16/99	BOONSBO	ORO.	MARYLAND		
permit. Pages Depertment of Important: If it any Injury or once.		21. Signeture of Funeral Service Lich	Paul M.	Dean			ess of Facility	7606 01	d Natio	nal I	Pike		
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/Medical		Immediate Ceuse (Finel		A	unt à	0		. 0			1.		
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iclan: The law requires that the de certificate has been signed by the rector, page 2 should be deteched								24e. Was	en eutopsv	24b. W	ere autopsy findings		
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ysician: The s certificate director, par	Be	25. Was cese referred to medical examiner?	Hospital:			Ott	nor:	eath (Check only or	*				
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or At after of Direct In by	ertit	4 ☐ Homicide determined	28e. Place of Injury building, etc. (S	Specify)	mi, street, iac	nory, onice		City or Tow	n, Stete)	er or mura	Il Houte Number,		
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To the Hospital or J within 24 hours after To the Funeral Dire completely filled in b	edicai	(Check only 2 Medical Exer	iner: On the basis of exa	amination and	dor investigat	lon, in my	opinion, death occ	e, end due to the c urred at the time, c	ause(s) end ma late and place, a	nner es si and due to	the cause(s)		
Vithir Comp	M	29b. Signature end title of certifier				29c. Licens	se number	2	9d. Date signed	d (Month,	Day, Year)		
		mult	10			D4	4996		Tune	14	1999		
		30. Name end address of person who	Completed cause of death	(item 22a) /	Type Drint\				J-7.00 7	//	1 1 1 1		
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	Physici /Medi		JOHN DENTON RE	ESE						JUNE	- '	999	4:00 A.M.
	Examir	ner	4a. Facility Name (If not Institution		umbar)					ocation of Deatl	h 4c. County	of Death	
_		_	16700 AQUEDUCT  5. Social Sacurity Number	DRIVE 6. Sax	7 Age //	n yrs. last birthday)	If Undar 1 Yas			SPORT 8. Data of Bir		HINGT	
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	Jeath	Funeral	27781 FORESTER  11. Marital Status	12. Was Da	cedant Eva	r in U,S. 13. V	341 Was Decedant of		igin? (Sp	ecify Yes or No		S.A. ca - Amari	can Indian,
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an	2 should end Men is marke		19a. Informant's Name/Ralation				ng Addrass (Stre						
Z (a)			LINDA S. REESE	/WIFE			FORESTE	R DRIV	E, E				RIDA
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UIVISION	X = = c	ertification:	3 ☐ Suicida 6 ☐ Could 4 ☐ Homicida datam	nined Zoa. Plac	a of Injury ling, etc. (S	At homa, farm, stra pecify)	aat, factory, offic	е		28f. Location (: City or Tox		oer or Rur	al Routa Number,
	To the Hospital or within 24 hours effe to the Funeral Dir completely filled in	edicai Ce	29a. Cartifiar 1 Certifyir	ng Phyaician: To the Examiner: On that	e best of m	y knowledge, death	occurred at tha	tima, dete en	d plece,	end dua to tha	cause(s) and m	enner es s	steled.
	the	Medi	510)	and mar	nnar statad.				Jocuir				
	O T WHO	-	29b. Signatura and titla of effiling	MI	_		29c. Lica	nsa number	60	0	29d. Data signe	0 (Month,	CO (Vear)
		-	30 Nama and admin of person	y W	no of d*	(Item 02a) (To-	Print)	16	00	0	6	00/	17
			A A A A	who complated cau	Un A	Han 23a) (Typa	(0) /	COR	No	bu 1	N2 2	17	42
	Sta	te	.1. Data filed (Month, Day, Year)		Ragintrar's	Signatura	1	3					
	Registra	ar	JUN 2	2 1999		1	. 1400	cos					



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middla, Last) Day 1999 WILLIAM DOUGLAS RUDE, SR. JUNE 0400 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) Days Months 235-84-5254 46 MAY 27, 1953 NEW JERSEY Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No BERKELEY FALLING WATERS 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number RT. 3, BOX 202 25419 USA 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Datas: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puarto Rican, atc.) 11. Marital Status 14. Rece - American Indian, Black, Whita, atc 1 Never Married 2 Married 1 ☐ Yas 2 XXIIo Specify Specify 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry MARYLAND CORRECTIONAL Eiemantary/Secondery (0-12) Coilega (1-4or 5+) SERGEANT TRAINING CENTER

deeth with the Marylend than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Pages 1 and 2 should be filed within 72 hours efter nent of Health end Mentel Hygiene. altimore, Maryland 21215-0020

**Physician** 

/Medical

Examiner

Director

Funeral

2

**Funeral** 

Director

Physician /Medical **Examiner** 

> Physician/Medical Examiner Be Completed by

attending physician and for use es the bunal-tran The law requires that the deeth certificate be exec signed by the a director, page 2 should certificate has To the Hospital or Attending Physician: "within 24 hours aftar death.

To the Funeral Director: After this certifica completely filled in by the funaral director; p. Medical Certification: To

P.O. Box 68760,

Division of Vital Records,

William

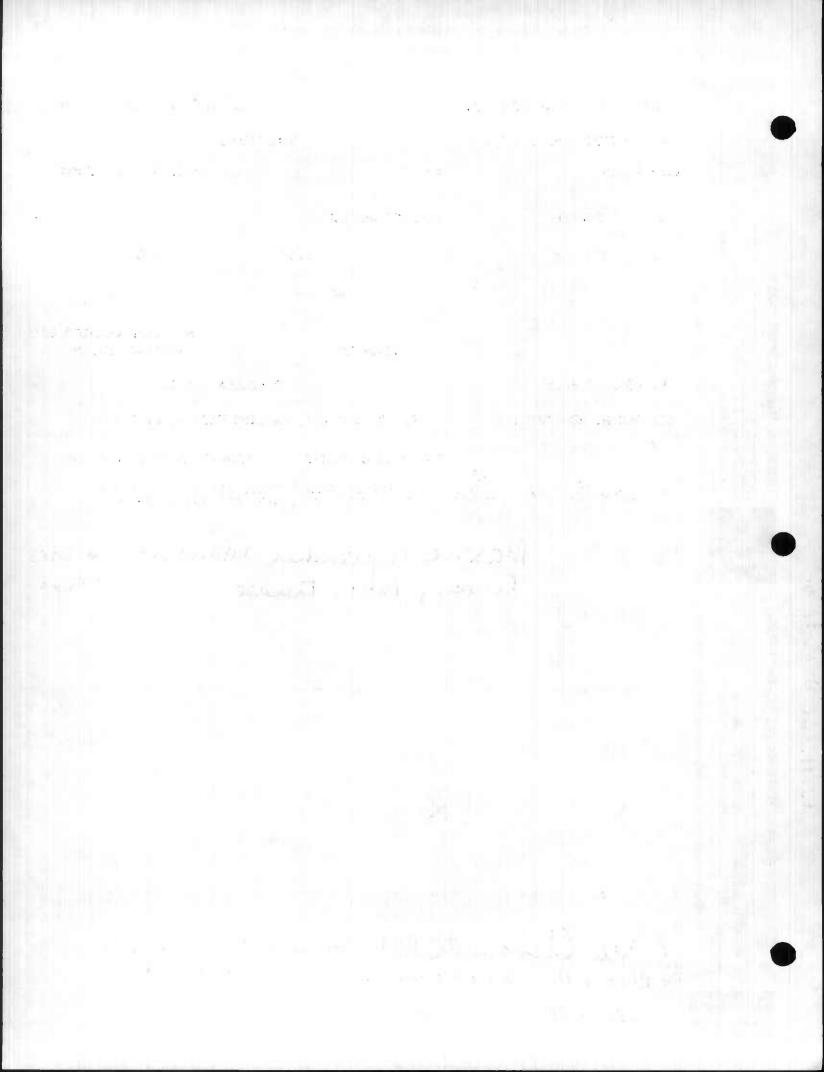
15. Decedant's E (Specify only highest gr	ducetion	16a. Decedant's Usual Occ (Giva kind of work do	cupation	orkina	16b. Kind of Bu	usinass/Industry	
15. Decedant's E (Specify only highest gri Elemantary/Secondery (0-12)  17. Father's Name (First, Middle, Last E . DOUGLAS RUDE	Coilega (1-4or 5+)	SERGEANT	ired)			D CORREC G CENTER	
17. Father's Name (First, Middle, Last		Daroami	18. Mother's Na	me (First, Middl	e, Meiden Sumen		
E. DOUGLAS RUDE			PRIS	CILLA S.	ACHSE		
19e. Informant's Neme/Ralationship	Type, Print)	19b. Mailing Addrass (Stre	et and Number or A	lure/ Routa Num	ber, City or Town,	Stete, Zip Code)	
DEBORAH D. RUDE/		RT. 3, BOX					
20a. Mathod of Disposition		Place of Disposition (Nama of		Data	1	City or Town, Sta	ata
1 ☐ Burial 2 ☐ Crametion 3 ☐		cematary, cramatory or other		6/11/100			
4 Donetion 5 Othar (Special	**	ROSEDALE CEMET		6/14/99	MARTIN	SBURG, W	V
21. Signature of Funaral Sarvica Licer	M. Brown	22. Nama and Ad BROWN FU	NERAL HOM	E, 327	W. KING	STREET	
23a. Part1. Enter the disease, or com shock, or heart failura. List only	plications thet caused the da ona causa on each line.					Appro	eximata al Between t and Death
Immediata Causa (Final disaasa or condition rasulting in daath)	a. Massiu	Cor as a consequence of	diel	Infar	dien	Mix	wtes
Sequentially list conditions,	b. Corona	(or as a consequence of):	Dsea	se		75	syrs
Sequentially list conditions, if any, leeding to immediate causa. Enter Undarlying Causa (Disease or injury that initiated avants rasulting in death) Last  Part II. Other significant conditions of the conditions of the cause o	cDua to	(or as a consequance of):					
Part II. Other significant conditions of	contributing to death but not r	esulting in the undariying causa	givan In Part I.	23b. Di	i tobacco use co	ntributa to the ca	ause of death?
				18	Yes 2 No	3 Probably	4 Unknow
					s an autopsy formed?	24b. Wara auto available complatio of deeth?	prior to
				1	Yas 2 No	1 ☐ Yas	2□ No
25. Wes case referred to medical axaminar?				ath (Check only	ona)		
1 ☐ Yas 2 No	Hospitei: 1 Inpatient 2	DETVOUIPALIENT SEL DON		Homa 5□Re	sidance 8 Oth	ar (Specity)	
27. Manner of Death 1 Natural 5 Pending 2 Accidant invastigatio	28a. Deta of Injury (Month, Day Year)		njuryat Vork? □Yas 2□No	28d. Describe	how Injury occur	red	
3 Suicida 6 Could not be determined		homa, farm, straat, factory, officity)	се	28f. Location City or T	(Street and Numb own, Steta)	ber or Rural Routs	Number,
29a. Cartifiar 1 Cartifying Pt (Check only one) 2 Madical Exer	nysician: To the bast of my k ninar: On the besis of exami and mannar stated.	nowiedga, daath occurrad at the netion end/or invastigation, in m	time, dete end plec y opinion, daath occ	e, end dua to th urred at tha time	a causa(s) and ma a, data and place,	annar as stated. and dua to the ca	iuse(s)
29b. Signeture end title of certifia		29c. Lica	ansa number		29d. Date signe	d (Month, Day, Y	ear)
1111	eranol	· NID M	000521	36	6/4	199	

State Registrar

31. Date filed (Month, Day, Year)

JUN 1 4 1999

30. Name and addrass of person who completed cause of deeth (Item 23e) (Type, Print) Williamsport Maryland Dr. Cliccarelli 3 Byrkit Drive Williamsport Maryland 32. Registrar's Signatura



## Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

iene	9	9	21	-	2	6
a No					6.40	~

				Cer	TITICAL	e or i	Death			Reg. No.			
Physician	1. Decedent's Name (First, Mid		in						2. Date of De Month	eath Day	Year	3. Tima of Death	
Physician /Medical	Edward Schlein							June	16	1999	7:40am		
Examiner	4a Facility Name (If not institution, give street and number) Continuum Care at Sykesville					4b. City, Town, or Lo Sykesvil					county of Death arroll		
Funeral Director	5. Social Security Number 216–14–3314	6. Sax 1 ☑ M 2 □ F			If Undar Months	1 Yaar If Under 24 Hrs. Days Hours Min.			8. Data of Bir (Month, Di May 25	1922	9. Birthplaca (State Country) Md		
P .	Usual Rasidenca of Decedent		I so Ch. Terre colored				***						
death with the Maryland ms 23a or 28s-f show from the room and neral Director	Md Balti		ore   10c. City, Town or Lo Baltimore							10d. Inside City Limi 1 ☐ Yes 2 🏋			
th with the 23a or 28	10e. Street and Number 5557 Channing Road			10f. Zip Code 21229						10g. Citizen of What Country? USA			
or he	11. Marital Status  1 Nevar Married 2 M/ 3 Widowed 4 Divorce	Armed F Irried 1 X Yes	1 Tx Yes 2 □ No			Vas Decedent of Hispanic Origin? (Specify Yas or Yes, specify Cuban, Maxican, Puarto Rican, etc.)  ☐ Yes 2【 No Specify:					No- 14. Race - Amarican Indian, Black, White, etc.  Specify: White		
naturel.		ent's Education lest grade complated,	ade complated) (Give		dent's Usual Occupation kind of work done during most of working				ing	16b. Kind of Busines		ndustry	
d withir giene.	Elementary/Secondary (0-12)	College	College (1-4or 5+)			Truck helper				A & P Company			
d out H	17. Father's Name (First, Middle Edward Louis S		18. Mother's Name (First, M Maud Mae Warf										
	19a. Informent's Name/Reletionship (Type, Print)  Sylvia Schlein (spouse)  19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  5557 Channing Rd., Baltimore MD 21229										p Code)		
8 0 = 9	20a. Method of Disposition  1 □ Burial 2 □ Cremation  4 □ Donation 5 □ Other	Cerr	ce of Disponetery, crem	natory or o	ther plac		6	Date -21-99	20c. Location - City or Town, Stata 99 Baltimore, Md				
pemit. Pa Departmer Important: any injury once.	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Haight Funeral Home & Chapel												
ding physician and seas the bunal-transit as the bunal-transit with a seas the bunal-transit and the bunal-tra	P.O. Box 195 Sykesville, Md 21784  23a. Part1. Enter the disease, or complications that sused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate interval Between												
	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last  Due to (or as a consequence of):  Convolution of the consequence o												
		d		0									
the ettend hed for us	Pert II. Other eignificant condi	tions contributing to	tributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contributa to the cause of dear					
that the death and by the etter detached for Physicia	-> Colonform Care co						nu	1	1□	Yee 2□ No 3□ Probably 4☑Unkno			
requires ignificant significant significan	COPD: - 02 and Ner ord dependent performed? 24b. Were autopsy available prompeters								Vere autopsy finding vailable prior to ompletion of ceuse				
The law ate hes b page 2 s							-		10	Yes 20 No		f déath?  ☐ Yas 2☐ No	
certificate rector, pag													
	examiner? 1 ☐ Yes 2 ☑ No	Hospital:											
After fune	27. Manner of Death 1 ⊠Natural 5 □ Pend	28a. Date	28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  28c. Injury at Work?  28d. Describe how injury occurred										
or Attending after deeth. Director: After I in by the fune ertification	3 Suicide 6 Coul	d not be 28a, Plac	e of Injury - At hom ding, etc. (Specify)	a, farm, str	aat, factor	y, offica			28f. Location City or To	(Street and Nu own, State)	ım <i>ber</i> o <i>r R</i> u	ral Route Number,	
To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
To the within To the comple	29b. Signeture end title of certifier  Living License number  29c. License number								29d. Date signed (Month, Dey, Year)				
	30. Name and address of parson	on who completed cau	use of deeth (item 2	(3a) (Type,				v-1	le R	i and .	- lu	intle 21	
State Registrar	31. Date filed (Month, Day, Yes		Registrar's Signatur	re A		200	//				O,		

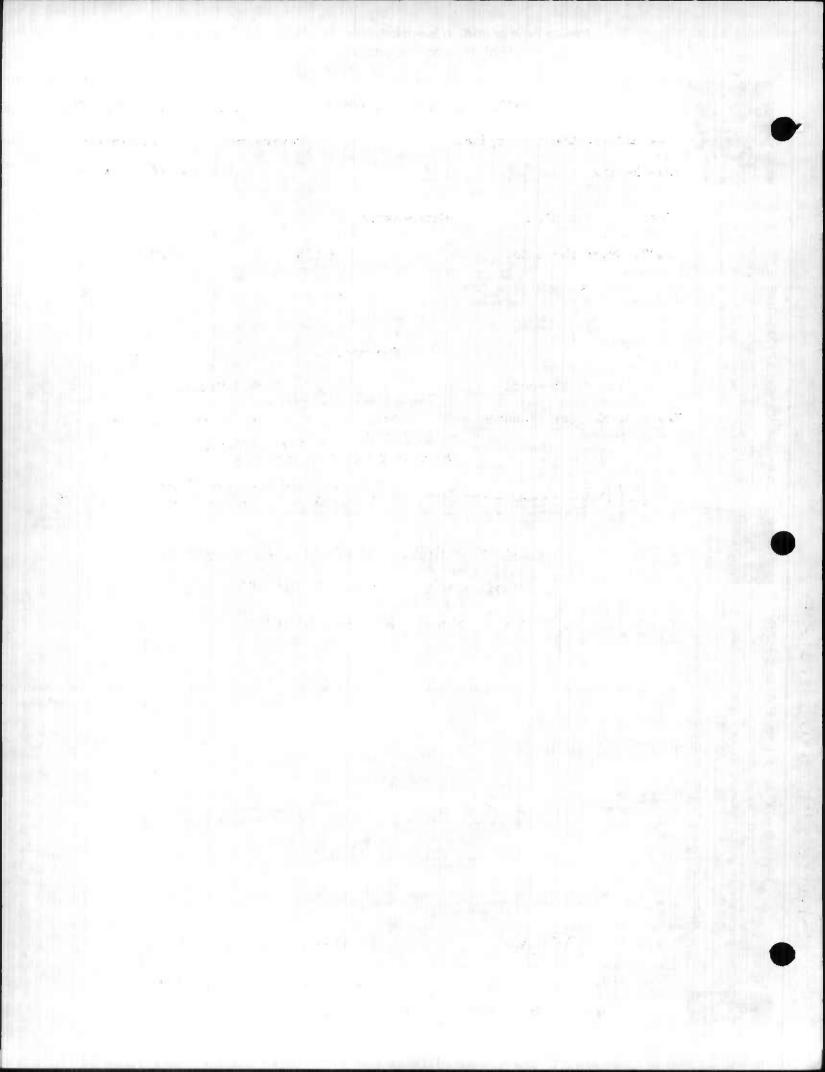
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# Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9

	Certificate of De	eath	Reg. No.											
sician	1. Decedent's Nama (First, Middla, Last)	2. Data of Do Month	Dey Year	3. Tima of Death										
edical	Martha Elizabeth Shaffer	June		0430										
miner		City, Town, or Location of Deal	ath 4c. County of Death											
		Hagerstown	Washing											
	Months Days	f Under 24 Hrs. 8. Date of Bi Hours Min. Month, D.	rth 9. Birth Cou. 1922 I	placa (State or Fore										
П	184-12-3382	Jan. 3	0, 1922   1	owa										
	Usual Rasidance of Dacedant  10a. Stata 10b. County 10c. City, Town or Location			10d. Inside City Lir										
-				1 ☐ Yas 2 🛣										
cto	Penna. Franklin Greencastle													
- in	10e. Street and Number 10f. Zip Coda		10g. Citizen of What Cou	ntry?										
B	13092 Grant Shook Rd. 1722	2.5	U.S.A.											
<b>Funeral Director</b>	11. Marital Status  12. Was Decedent Ever In U,S. Armed Forcas?  13. Was Dacedant of Hispa	anic Origin? (Specify Yas or N Maxican, Puarto Ricen, atc.)	o- 14. Race - Amar Black, White											
	1 ☐ Nevar Merried 2 ◯ Married 1 ☐ Yes 2 ☒ No If Yes, Giva 1 ☐ Yes 2 ☒ No S	Specify:	Specity: Wh	ite										
2	3 ☐ Widowed 4 ☐ Divorced Yaar or Datas:													
TO THE PERSON NAMED IN	15. Decedant's Educetion (Specify only highast grada complated) (Give kind of work dona durii life. DO NOT usa ratired)	on ing most of working	16b. Kind of Businass/li	ndustry										
ğ	Elemantary/Secondary (0-12) Collega (1-4or 5+)													
S	12 Homemaker		Home											
Be Completed	17. Fether's Name (First, Middla, Last)	3. Mothar's Nama (First, Middle	e, Maiden Sumame)											
10	William E. Ebersole	Rachel Gary	vick											
	19a. Informant'a Name/Reletionship (Typa, Print)  19b. Mailing Addrass (Street and	Number or Rural Routa Numi	ber, City or Town, Stata, Z.	p Coda)										
	Frank D. Shaffer /Husband 13092 Grant S	hook Rd. Green	ncastle, Pa.	17225										
	20a. Mathod of Disposition  1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from Stata	Data Data	20c. Location - City or T	own, Stata										
	1  Buriel 2 □ Cremation 3 □ Removal from Stata 4 □ Donation 5 □ Othar (Spacify) Church Of The Brethren	Comptety	Upton, Pa											
	21. Signature of Funaral Sarvice Licensee 22. Nama end Address of Fecility													
		And Son Funera												
_	45 S. Carlisle St. Greencastle, Pa. 17225  23a. Part 1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest,  Approximate													
	shock, or haart failure. List only ona ceusa on aach line.	such as cardiac of raspiratory	arrast,	Interval Batwas Onset and Das										
/Medical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Lest  Due to (or es e consequence of):  END STAGE RENAL D  Due to (or es a consequence of):	ISEASE												
Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.  23b. Did tobacco use contribute to the cause of death													
hy			1 Yes 2 No 3 Probably 4											
by F														
B		24e. We	s en eutopsy 24b. V	Vara autopsy find vallable prior to										
let		per	0	ompletion of ceus										
Completed														
S	or Westernational and the second			□Yas 2□No										
Be C	exeminar?	6. Place of Death (Check only												
- L	1 Inpetiant 2 ENOutpatient 3 DOA	4 ☐ Nursing Homa 5 ☐ Ras	sidence 8  Other (Spec how injury occurred	erry)										
edicai Certification:	1. Natural 5 Panding (Month, Day Year) Injury Work?	s 2 No												
Ca	3 Suicida 6 Could not be		(Streat and Number or Ru	ral Pouta Numba										
F	4 Homicida  28a. Placa of Injury - At home, farm, streat, factory, office building, atc. (Spacity)	City or To	own, Stata)	rai riodia ivaliboi										
ပ္														
cal	29a. Cartifiar (Check only   Medical Examiner: On the basis of axamination and/or invastigation, in my opini	data and place, and dua to the ion, daath occurred at the time	a causa(s) end menner as i, data and placa, and dua	stated. to the causa(s)										
B	one) and mannar stated.													
Σ	29b. Signeture end title of cartifier 29c. Licanse no		29d. Data signed (Montl	, Day, Year)										
	DOC	53548	06/21/19	177										
	30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)		1											
	Dr. Monzur 12931 Oak Hill 6	Ave. Hag.	md 21	742										
ate	31. Data filad (Month, Day, Year) 32. Registrar's Signatura													
ar	JUN 2 2 1999 . Apacks	/												

DHMH 16 Rev 6/95

Shaffer, Martha Elizabeth



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

			nd / Department of Certificate o			g. No.		
	1. Decedent'a Name (First, Middle,	Last)			2. Date of Death		3. Time of Death	
ysician Jedical	Ross	Harvey	SPICKL		June 16 Location of Death	, 1999	6:00 AM	
aminer	4a Facility Name (If not institution,  Clearview Nur	STATE OF THE STATE		Hagersto		4c. County of Death WASHINGTON		
eral		S. Sex 7. Age (In yrs.	last birthday) If Under 1 Yea	ar If Under 24 Hrs	8. Date of Birth		Birthplace (State or Foreign Country)	
ctor	216-14-6236 Usual Residence of Decedent	1MM 2□F 90	Yrs. Months Day	s Houra Min		lay 20, 1909 Maryland		
leted by Funeral Director	10a. State 10b. County  MD Washin		ty, Town or Location Hagerstown				10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
by Funeral Director	10e. Street and Number	gron	10f. Zip Code		10	g. Citizen of Wi	nat Country?	
O	9946 Downsvill	e Pike		21740		USA		
ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was Decedent o		Specify Yes or No-	14. Race	- American Indian, White, etc.	
F	1 ☐ Never Married 2 ☐ Marrie		1 ☐ Yea 2 ⊠ N		to riloan, oto.,	Specify:	, wille, etc.	
	3 Widowed 4 □ Divorced	Year or Dates:		оргону.			White	
etec	15. Decedent's (Specify only highest	Education grede completed)	16a. Decedant's Usuai Occ (Give kind of work dor	e during most of wo	orking	6b. Kind of Bus	iness/Industry	
Be Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use reti	red)		Maahina	Tool Mont	
ပိ	17. Father's Nama (First, Middle, Li	0	Machinist	19 Mathada Na	me (First, Middle, N		Tool Manf.	
Be		157)	0 : 1 1			elderi Surriame		
2	Harvey	(Time Print)	Spickler	Lilli		City or Town S	Pittinger	
	19a. Informant's Name/Relationshi		19b. Mailing Addrass (Stre					
	Louise E. Drape	20h.	Place of Disposition (Neme of		Rd. Willi	amsport	MD 21/95 City or Town, State	
	1 ☑ Burial 2 ☐ Cremation 3	Removal from State	cemetery, crematory or other post Haven Cemet					
	4 □ Donation 5 □ Othar (Spe	1			10,1999 П	agersio	WII, MD 21/42	
	21. Signature of Juneral Service D	cansed	22. Name and Add OSBORNE	FUNERAL H	OME			
	P///09~//1/.C	14-	P.O.Box	# 348 Wil	liamsport	, MD 21		
	23a. Part1. Enter the disease, or conshock, or leart failure. List of	omplications that caused the dea nly ona causa on each lina.	th. Do not enter the mode of o	lying, such as cardia	ac or respiratory arre	st,	Approximate Interval Between	
		4 3					Onset and Death	
	Immediate Cause (Final disease or condition resulting in death)	a. Muto	Bronchops	comor	en		2 weeks	
2	resulting in dealth)	Dua to (	or as a consequence of):	. /	-		Many	
Examiner		b. Cheon	à de betradire	Pulin	gray D.	were	9.44	
xan	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Dua to (	or as a consequance of):					
cai	cause. Enter Underlying Causa (Disaasa or injury that initiated evants	C						
_	resulting in death) Last	Due to (	or aa a consequenca of):					
Š		d						
Cia					ant state			
Physician/Med	Part II. Other significant condition				tribute to the cause of death?			
by P	Dementia !	1 alpherm	ni /yre			2010	Day Todally 4 Dilkilow	
					24a. Was a		24b. Were autopsy findings	
iete					perform	ned?	available prior to completion of cause of death?	
Completed					400	, almai		
						S Z NO	1 ☐ Yea 2 ☐ No	
Be	25. Was casa referred to medical examiner?	Hospital:		Thor	ath (Check only on			
70	1 Yes 2 No	1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3☐ DOA ☐ 28b. Time of ☐ 28c. In	Nursing	Home 5 ☐ Reside			
on	1 ☐ Natural 5 ☐ Pending	(Month, Dey Year)	Injury V	vork? ☐ Yes 2 ☐ No	200. 2000.00 110	wanty cocarre		
Certification:	3 Suicide 6 Could no	t be 28e. Place of Injury - At h	noma, farm, street, factory, offic	28f. Location (Street and Number or Rural Route Number,				
Cert	4 Homicide	building, etc. (Speci	ry)		City or Town	, Siele)		
	29a. Cartifier 1 Certifying (Check only one) 2 Medicat Ex	Phyeician: To the best of my known in the common co	owledge, death occurred at the ation and/or investigation, in m	time, date and place y opinion, daath occ	ea, and dua to the ca curred at the time, de	usa(s) and man	ner as atated. nd dua to the cause(s)	
dica						2d Data sispad		
Medicai	29b. Signature and title of certifier		29c. Lice	nse number	29d. Date signed (Month, Dey, Year)			
Medica	29b. Signature and title of certifier	and a	29c. Lice	nse number	25	d. Date signed	(Month, Day, Year)	
Medica	29b. Signature and title of certifier  30. Nama and addrass of person w	ho completed cause of death (Ite	0	007557	25	4/1	(Month, Dey, Year)	

DHMH 16 Rev 6/95

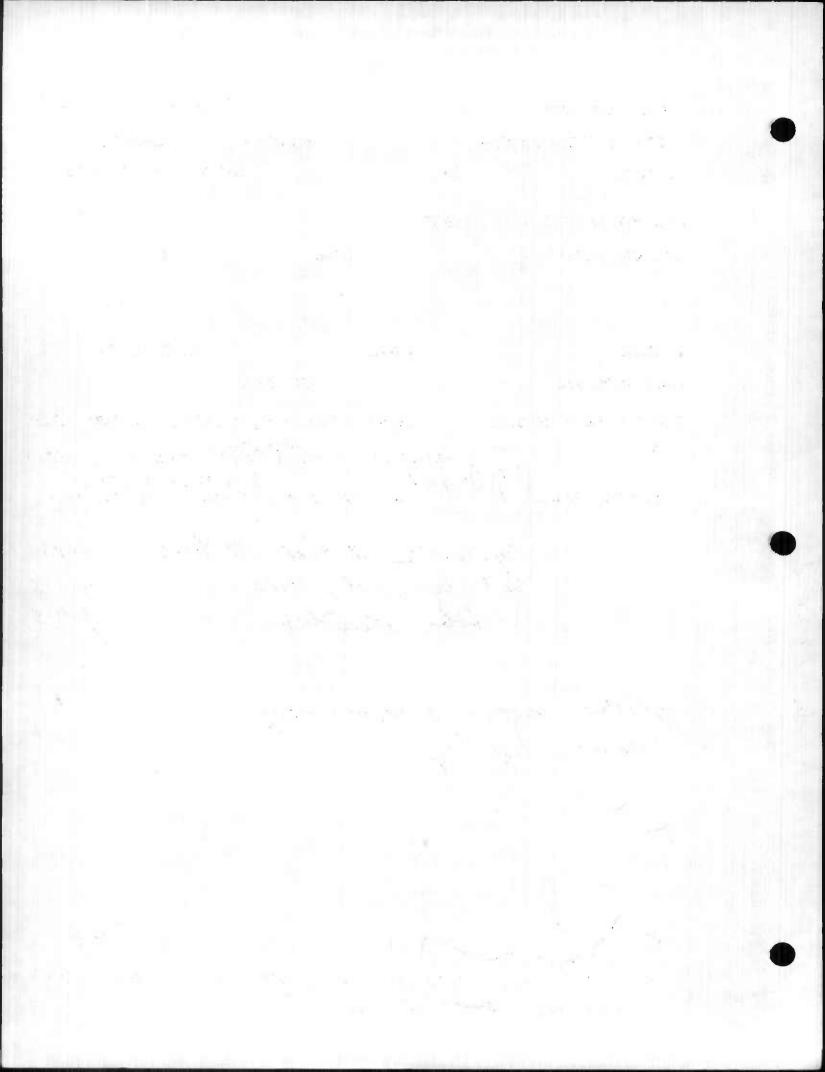
State Registrar



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	Dhunisia		1. Decedent's Nemo	e (First, Midd	lle, Last)							2. Date of De Month	ath Day	Yeer	3. Time of Death		
	Physicia /Medica		MARGARET	FLO SA	ANDY							June		999	1625		
	Examine		4a Facility Name (I	f not institution	on, give stre	et and numi	ber)				4b. City, Town, or L	ocation of Death	4c. County	of Death			
		П	WASHINGTON COUNTY HOSPITAL									WN	WASI	HTNGTO	N		
	Funeral		5. Social Security N		6. Sex 7. Age (In yrs. lest birthday) If Under 1 You Months De						If Under 24 Hrs.	8. Date of Bir			ice (State or Foreign		
	Director		214-28-05	86	1 M	2 <b>X</b> F	68	Yrs.	Months	Days	Hours Min.	MAY 20	1931	MARYI	AND		
٠,	10		Usual Residence of														
	Man Man		10a. State	10b. County	У		10c. C	ty, Town or	Location					10	d. fnside City Limits		
	the Maryla 28e-f show notified at	to	MARYLAND	WASHT	INGTON	J	HAC	ERSTO	MN						Yes 2□No		
	170 170 170	Directo	10e. Street and Nur		210201		1111	IMEDIO	10f. Zip	Code			10g. Citizen of	Whet Countr	γ?		
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Maryland 21215-0020	of puring		19a. Informant's Ne	me/Relation	ship <i>(Type</i> ,	Print)		19b. Me	iling Address	(Street	and Number or Rui	ral Route Numb	er, City or Town,	State, Zip (	Code)		
Σ	24 E		JOSEPH A.	SANDY	Z. SR.	/SON		9426	STOTT	LEM	YER ROAD,	BOONSB	ORO. MAI	RYLANT	21713		
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Ba	Maps Maps May I		4 Donation 5 Other (Specify)  BETHEL UNITED METHODIST CEMETERY ROHRERSVILLE, MARYLAN  21. Signature of Funeral Service Licensee  And Address of Facility  7606 OLD NATIONAL PIKE														
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	Physician													4	Onset and Death		
1	/Medical		Immediate Cause (	Final		5000	tical	416	m	sta	Inplie!	40ide	sis		DAVS		
	Examiner	1	Immediate Cause (Final disease or condition resulting In deeth)  Due to (or es e consequence of):												/-		
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	be axecuted ician and burial-transit	Examiner	Sequentially list conditions  b. fill the fill t											1			
Ć.	axecuin and ial-trar	Ž	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury c.)										years				
68760,	cata be ay physician the buria	ig ig	Cause. Enter underlying Ceuse (Disease or injury that initiated events  Due to (or as a consequence of):										7/ "/				
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ď.	that the death certified by the attending detached for use a	Completed by Physician/M	5/28	Ke	m	ptab	tobelic anceshalo path					1 Yes 2 No 3			ably 4 Unknown		
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≥	or At after of Direction by	₹	4 Homicide	deterr	mined		g, etc. (Spec		street, factory	, office		City or To	Street end Num wn, Stete)	Der or Hurai	Hobie Number,		
	tal a le	ပီ		-	0												
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completaly filled in by the funeral director.	edical Certification:	29a. Certifier (Check only one)	/i□ Certifyi 2□ Medical	ng Physici I Examiner:	an: To the bas on the bas and menne	is of examin	owledge, de ation and/or	ath occurred a investigation,	in my o	me, date and piece, opinion, death occur	, and due to the red et the time,	cause(s) and m date and piaca,	anner as sta and due to	ited. the cause(s)		
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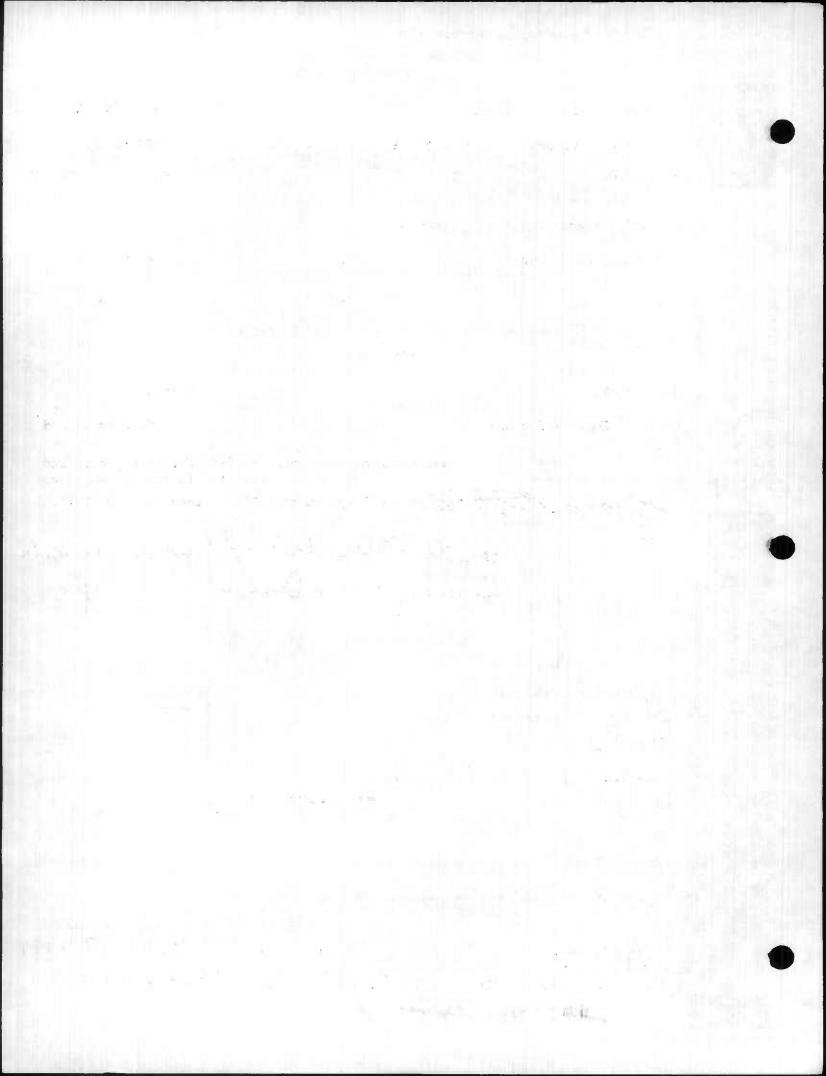


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State of Maryland / Department of Health and Mental Hygiene 9 9

21130

						Cei	rtifica	te of	Death		R	g. No.	-				
	1		me (First, Middle, La	ist)							2. Deta of Deet Month		Van	3. Time of Death			
	Physiciar Medica/	H'mm a	L.	Stine	e						June	16,	1999	2:00 P.1	M.		
	Examine	An English Name	(If not institution, given	a street and number	er)				4b. City, To	own, or L	ocation of Death	4c. Count	y of Deeth				
		1 West Moser Road Apartment 2-A Thu							Thur	mont		Fre	ederio	ick			
F	uneral	5. Social Sacurity Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24							8. Date of Birth	of Birth o, Day, Year) 9. 8		Birthplaca (State or Foreign Country)					
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aryte	d d	10a. Stete 10b. County 10c. City, Town or Location											1	0d. Inside City Limits 1 ☼Yes 2 ☐ No			
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aryiand 21215-0020 should be filed within 72 hours efter deeth with the Manyland	Tis marked other than "natural", or thems 23s or 28s-1 show traumatic event, the Medical Examiner must be notified at To De Commission by Example 1995.		rried 2 Married  4 Divorced	1 ☐ Yes 2 ☑ If Yes, Give Yaar or Datas		1 ☐ Yes 2 ☒ No Specify:						Specia	y: wh	ite			
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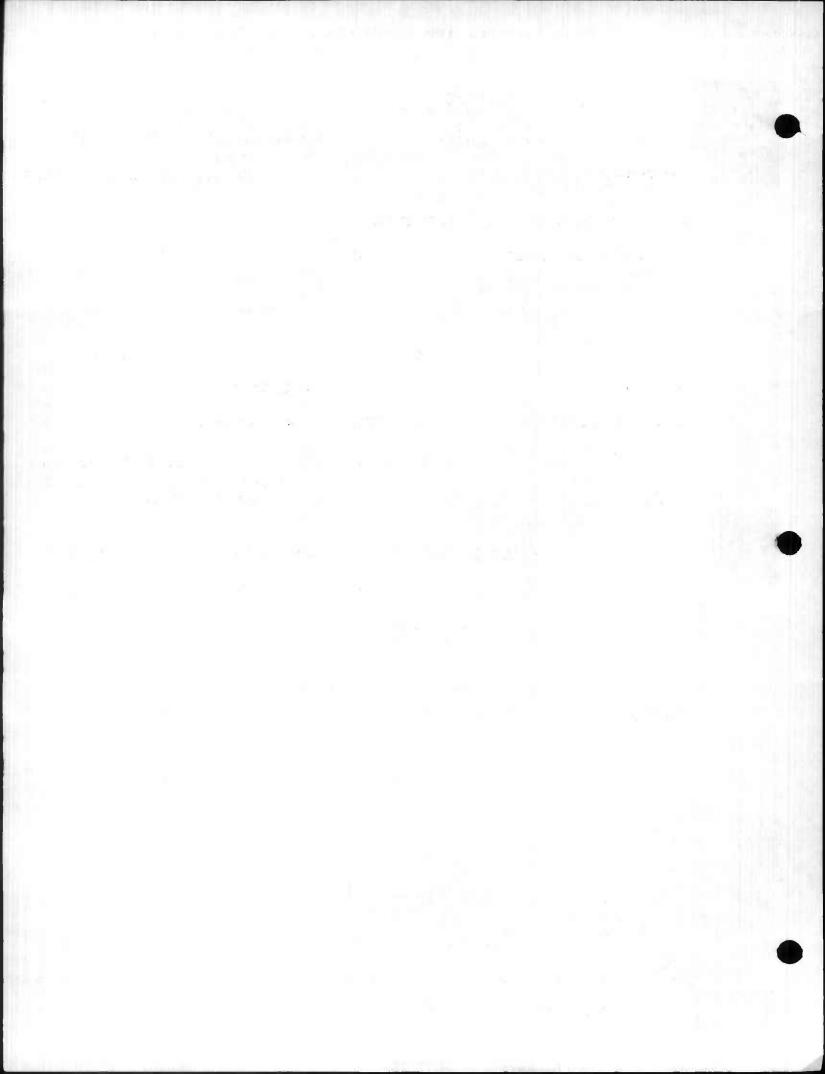
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** KUDOLF WILLIAM JUNE /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Deeth 4c. County of Death Examiner HASERSTOUR 323 NOKTH WASTINGTON JONATH AN ST 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 110M 2□ F Months Days Yrs. Director 218-26-0429 68 AUG 24, 1930 CHARLES TOWN, WV Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified Director 1 Ves 2 No MD WASHINGTON HAGERSTOWN 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code ò itетя 23a 323 N. JONATHAN STREET 21740 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No It Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Raca - American indien, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 ☐ Married altimore, Maryland 21215-0020 ŏ 1□ Yes 2♥ No Specify: by Specify 3 Widowed 4 Divorcad "natural", BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Eiementary/Secondary (0-12) Coilege (1-4or 5+) 8 ORDERLY CITY HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental DANIEL T. TAYLOR 2 EDNA BROWN 19a. informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Depertment of Health and Important: If Item 27 Is m any Injury or other traum 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) DANIEL TAYLOR/BROTHER 27 GLYNDON DR., REISTERTOWN, MD 20b. Placa of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SMITHSBURG CREMATORY SMITHSBURG, MARYLAND 21. Signature of Funeral Service Licansee 22. Name and Address ot Facility BROWN FUNERAL HOME, PO BOX 821, 327 W. KING ST., MARTINSBURG, WV TORDEUX 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heert tailure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner BUPHAGUAL VARIOUS YBARS The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last physician s the burie ALCO HUL Box 68760. CONSUMPTION Physician/Medical Due to (or as e consequence of): P.O. Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ABNORMAL LIVER FUNCTION TESTS Records, Completed 24b. Were autopsy tindings available prior to 24a. Wes an autopsy completion of cause of death? page 2 2 NO No 1 Yes 1 ☐ Yes 2 ☐ No Vital Physician: Be 25. Was case reterred to medical 26. Place of Death (Check only one) exeminer/ 1 Ves 2 □ No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 Division o his 27. Menner of Death Date of injury (Month, Day Year) 28c. injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Ather or Attending 5 Pending investigation 1 Yes death 2 Accident a after death 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, State) AG SE 4 Homicke within 24 hours of To the Funeral C 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the ceuse(s) and manner as stated.

Madical Exeminar: On the besis of examination and/or investigation, in my opinion, death occurred et the time, date end piece, and due to the cause(s) and manner stated. Medical (Check only å 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 040622 mo 30. Name and address of person who completed cause ot death (item 23e) (Type, Print) 19236 MEADOW VIEW PR, AASBRITOWN MM MA CANN-MD 32. Registrer's Signature 31. Date filed (Month, Day, Year) State JUN 2 4 1999

Registrar

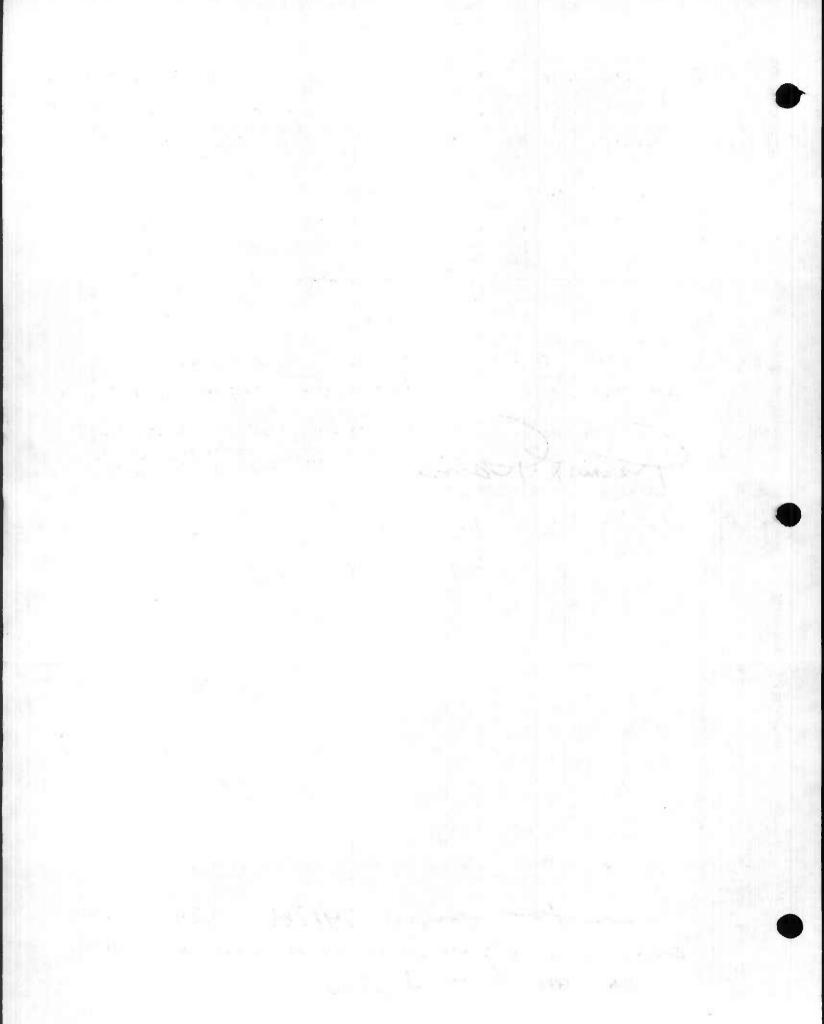


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State of Maryland / Department of Health and Mental Hygiene

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Funeral Director	ner			great				Month JUN	2 9°2,	1999	6:15 P.M.	
Director			amplaine	Dr.			Jeffer		Fre	ederic		
dand ow		5. Social Security Number  489-48-6679  Usual Residance of Decedent	6. Sex XX M 2□ F	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Yes		frs. 8. Date of Month,	Birth Pearly 46	9. Birthple Countr	oce (State or Foreig	
ne Maryland 18a-f show	ector	10e. Stete 10b. Coun  Md. Fre	ny ederick	10c. City,	Town or Lo	Jeffer					d. Inside City Limit	
23a or 2	Funeral Director	10e. Street end Number 4821 Ch	namplaine	Dr.		10f. Zip Code 217			-	on of Whet Country? U.S.A.		
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  And Health and Mental Hygiene.  Or other traumatic event, Ira Marical Examinating the profiled at or other traumatic event.	by	11. Marital Stetus 1 □ Never Merried 2 ☑ Ma 3 □ Widowed 4 □ Divorce	Armed F	2 No 65-68	11	<ol> <li>Was Decedent of Hispenic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Rin 1 ☐ Yes 2 ☒ No Specify:</li> </ol>			Ble	ce - America ck, White, ei y: White	tc.	
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permit. Peges 1 and 2 s Department of Health at Important: If Item 27 is any Injury or other trau	201	20a. Method of Disposition 1 □ Burial 2 □ X remetion 1 □ Conation 5 □ Other (	3 Removal from	State Cen	20b. Placa of Disposition (Name of commetery, crematory or other place)  Smithsburg Crematory June 13, 1999 Smithsburg, Ma							
permit. Departimental importu		Signature of Fuheral Service	a Licenter	tavi	> 22 D	Name end Add	tress of Fecility neral Ho	me 12525 Smith	Bradburg, Ma	y Ave.	83	
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Attending or death. ector: After by the fune	Certification: T	3 ☐ Suicide 6 ☐ Could	tigation I not be	of Injury  nth, Day Year)  e of Injury - At homiling, atc. (Specify)	8b. Time of Injury e, farm, stre		uryet ork? ⊒Yas 2 ☐ No				Route Number,	
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Sta Registra		30. Nama and address of person  LANAN HUD  31. Date filed (Month, Day, Yaar  JUN 17	HUD, MD	sa of deeth (Itam 2: 20   To L Degistrer's Signatur	-LHO	Spare	E-03	FREDER	ick, ml	217	6/	



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month Day Year **Physician** KOBERT HARTZEL WINGERD 1999 10:45 AM JUNE /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 2005 SANDYMOUNT ROAD FINKSBURG CARROLL 8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Hours Days 1⊠M 2□ F Months 200-24-0034 71 MAY10,1928 PA Director Usuel Residence of Decedent the Marylend 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23e or 28a-f show traumatic event, the Medical Examiner must be notified at MD CARROLL 1 Yes 2 No FINKSBURG Director 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code with 21048 UNITED STATES 2005 SANDYMOUNT Funerai ROAD death 12. Was Decedent Ever in U,S. Amped Forces? 1 ¼ Yes 2 ☐ No If Yes, Give 1 9 5 0 — 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Marital Stetus Pages 1 and 2 should be filled within 72 hours effer or nent of Health and Mentel Hygiene. nt: if Item 27 ie marked other than "natural", or item 1 Never Married 2 Married Maryland 21215-0020 TY Yes, Give Yeer or Detes: 1950-52 1 Yes 2 No Specify: Specify: A WHITE 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER DATRY 11 18. Mother's Neme (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be SIMON C. WINGERD DELLA WAGNER 19a. Intorment's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) EDITH WINGERD/WIFE 2005 SANDYMOUNT ROAD, FINKSBURG MD 21048 other altimore. 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 ♣ Cremetion 3 ☐ Removal from State 6 permit. Page Department o Important: If any injury or CARROLL CREMATORY 6/18/99 4 ☐ Donetion 5 ☐ Other (Specify) HAMPSTEAD, MD 91 WILLIS STREET 21. Signature of Funorel Service Licenses 22. Name end Address of Facility MYERS FUNERAL HOME WESTMINSTER, MD 21157 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medical Immediate Ceuse (Fine) disease or condition resulting in deeth) Examiner Examiner buriel-transit certificate be executed Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in death) Lest Due to (or es e cons pue P.O. Box 68760. physician Physician/Medical the Due to (or es e consequence of): 98 ettending use Po 23b. Did tobacco use contributa to the cause of death? the bec Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. detech signed by t 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. P The law requires 24b. Were eutopsy findings evallable prior to completion of cause of death? 24a. Was en eutopsy Completed peen performed? hes page 2 1 Yes 2 No 1 Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifice director, 25. Wes case reterred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Reeldence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? 5 Pending investigation 1 Neturel Injury 2 No 1 Yes 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 | Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifies 30. Name and eddress of person who complete Alva S. Baker MD who completed cause of deeth (Item 23a) (Type, Print) resville MD 21784 Avenue 7200 31. Date filed (Month, Dey, Year)

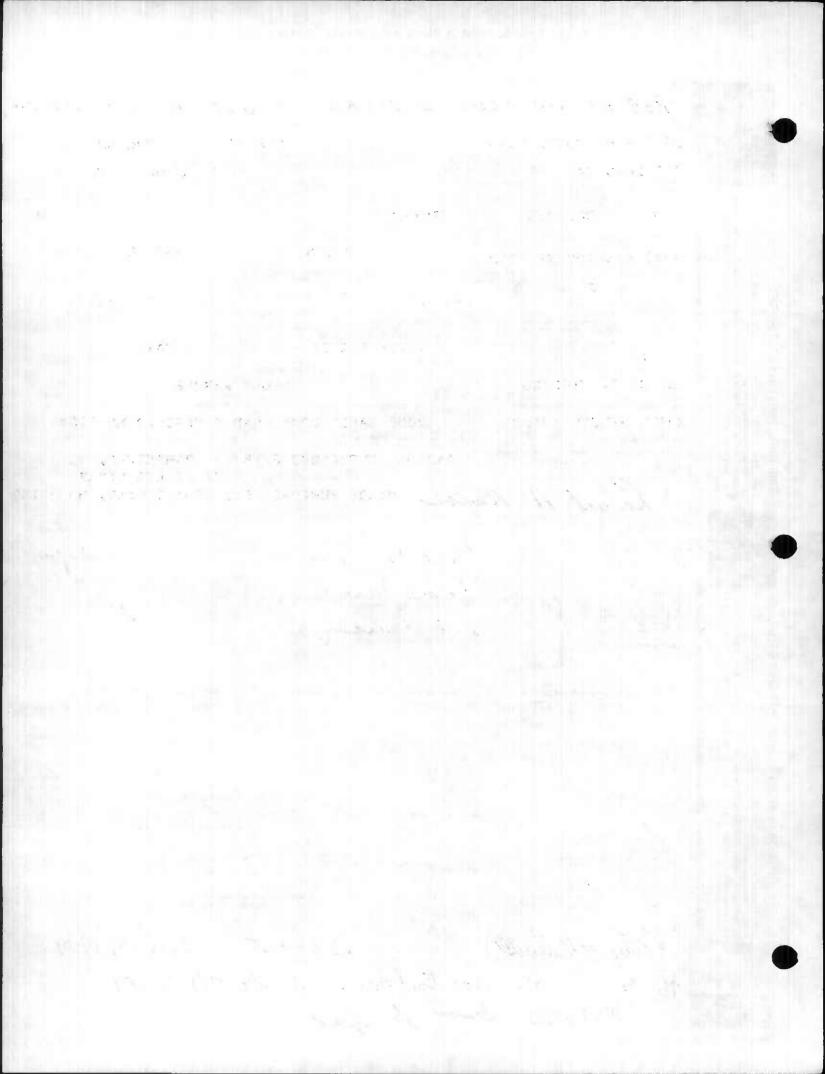
32. Registrer's Signature

JUN 1 8 1999

DHMH 16 Ray 6/95

State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Wheeler Dey Month **Physician** 1040€ June 15 1999 1:40am /Medical 4c. County of Death 4e Facility Name (If not institution, give stre et and number) 4b. City, Town, or Location of Death Examiner Gen 1705A Westwenster County If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) Jan 29 1942 5. Sociel Security Number 7. Age (In yrs. last billhday) **Funeral** Days Months Hours 220-38-3379 1 ☐ M 2 🕽 F 57 Director Washington DC Usuel Residence of Decedent 10c. City, Town or Location Sykesville 10a, Siete Md 10b. County 10d. Inside City Limits Show the Medical Examiner must be notified at Carroll Director 1 ☐ Yes 2 No 284-1 10e. Street and Number 6655 Sykesville Road 10f. Zip Code 10g. Citizen of What Country? 23a or 21784 USA death Funeral Hems : 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Meritel Status Black, White, etc. filed within 72 hours after 1 Never Merried 2 Merried 1 Yes 2 No natural, or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify.white à 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) teacher education permit. Pages 1 and 2 should be file Department of Health end Mental Hy, Important: If flem 27 is marked oths any injury or other traumatic event, page. 17. Father's Neme (First, Middle, Last)
Richard Martin Reamy 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Rita Purcell 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 635 W. Wisconsin Ave, Orange City, Fla 32763 Deborah Mullins (sister) 20b. Place of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, Stete 1 DBuriel 2 Cremetion 3 Removel from Stele Springfield Cemetery 6-19-99 Sykesville MD 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Fecility, Haight Funeral Home & Chapel 21. Signeture of Funerel Service Licenses Paine Haight Derbert P.O. Box 195 Sykesville MD 21784 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feliure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Fine) disease or condition resulting in death) Examiner Examiner SONGA iclan and burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest that the death certificate be execu physician the burial Box 68760. Physician/Medicai esn P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tohacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Records. þ 88 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was en autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Netural 5 Pending deeth. 1 TYes 2 No investigetion 2 Accident 24 hours after deet Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) Medical 2 Medical Examiner: On the basis of examend menner steted. (Check only one) within 2 29b. Signature and title of certifier. 29c. License number 29d. Det signed (Month, Day, Year) MD # D44614 Jeus-ut 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Stoner Ave Westminster Steers mo 295

DHMH 16 Rev 6/95

Registrar

31. Dete filed (Month, Dey, Year)

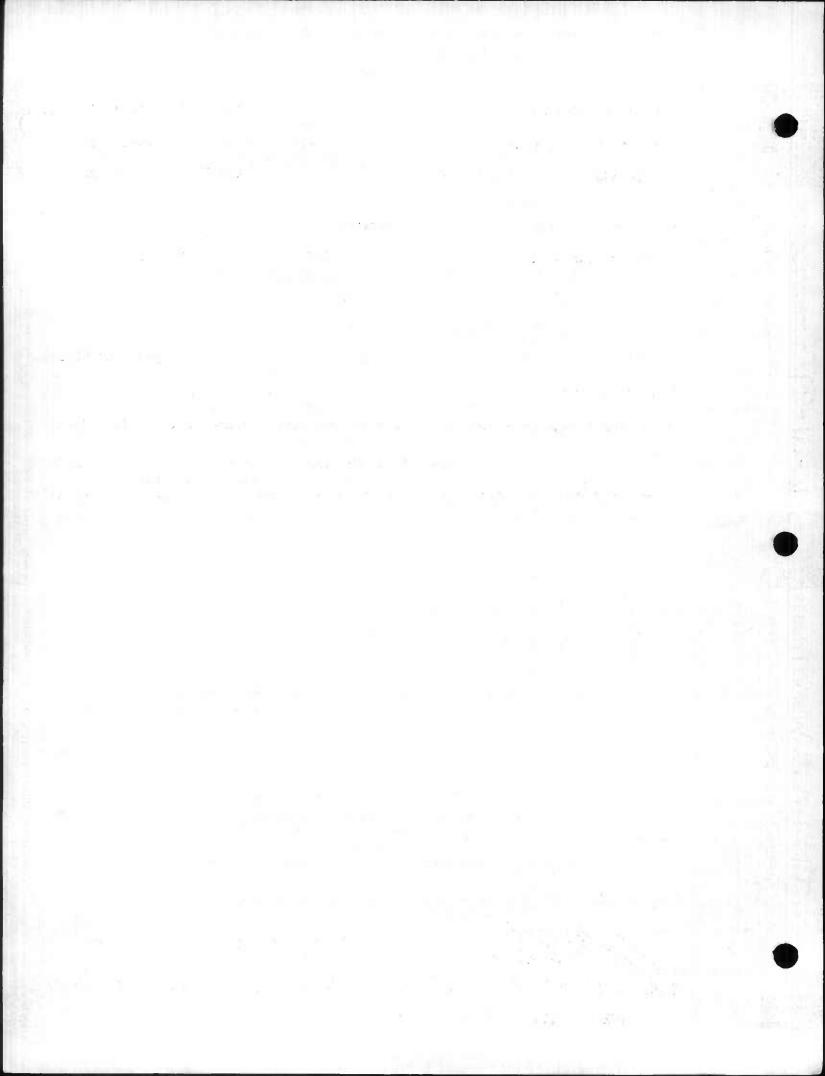
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32. Registrar's Signature

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	1 등 등 등	Certifi	4 ☐ Homicide determined	28e. Place ot Inj building, at	ury - At homa, fa c. <i>(Specify)</i>	rm, straat, facto	ory, office		28f. Location (5 City or Tox	Street and Numb vn, State)	er or Rural	Route Number,
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			30 Names and address of person who	completed cause of d	eath (Item 23a) (	Type, Print)	A	re 14	WOIS	Qua	no	545/2
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153/	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28a-f show any injury or other treumatic event, the Medical Examiner must be muiting and injury.			5 ☐ Other (Speci)	1 4	F	Rest l	laven	Cemete	ry Ju	ne 21	,1999	Hagers	town,	MD 2174	42
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		-	30. Name end addre	iss of person way	compléted caus	se of death	(Item 23a)	(Type, Prir	nt)	)	, ,	/		-	1	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day Year **Physician** HELEN 04, **ADAMS** 1:30 PM JULY 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 1021 KINGSTON ROAD PIKESVILLE BALTIMORE If Under 1 Year 6. Date of Birth (Month, Day, Year) 02-06-1912 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 M 2 K F Yrs. 87 Director 212-03-7273 MARYLAND Usual Residence of Decedent death with the Manyland 10a State 10b. County 10c. City, Town or Location **ehow** 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo **MARYLAND** BALTIMORE PIKESVILLE 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 1021 KINGSTON ROAD Funeral 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Bleck, White, etc. flied within 72 hours after 1 Never Married 2 Merried 21215-0020 1 ☐ Yes 2XXNo Specify: P Specify: 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 YEARS SECRETARY EPISCOPAL CHURCH 7 is marked other traumatic event, Baltimore. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be . Pages 1 and 2 should be fill ment of Health end Mental Hant: If item 27 is marked oth jury or other traumatic even 2 UNKNOWN UNKNOWN 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 21204 H. Emslie Parks 102 W Pennsylvania Avenue Suite 600 Towson, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Department of Important: If any Injury or page. BALTIMORE/WASHINGTON CREM, 7/9/99 LAUREL, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) m of Funeral Service Licenses 22. Neme end Address of Fecility
LORING BYERS FUNERAL DIRECTORS, INC. 8728 LIBERTY ROAD RANDALLSTWON, MARYLAND 21133 WAYNE OSTERLING e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, List only one cause on each line. Approximate Intervat Between Onset end Death **Physician** /Medical Immediate Cause (Finet disease or condition resulting in death) 00 Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of) US0 88 signed by the et d be deteched for Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? ORYes 2 No 3 Probably 4 Unknown e Vulnon Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en autopsy performed? es tartes page 2 this certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No **Olvision of Vital** Attending Physician: Be director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation Netural deeth. 1 Yes 2 No 2 Accident after deeth Director: the state of 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) in by 4 Homicide 8 To the Hospital or within 24 hours aft To the Funeral Di completely filled in Decertifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

State Registrar 31. Date filed (Month, Day, Year) 0 6 1999

29b. Signature and title of certifie

TAHOORA

KAWAJA 32. Registrar's Signature

Callo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PC

**DHMH 16 Rev 6/95** 

29c. License number

eister

125112

29d. Date signed (Month, Day, Year)

town Rd #108

1999

Baltinge H021208

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day **Physician** Garnett 1999 Fourth 0329 JUK /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Hopkins Bayview Medical Bultimore If Under 24 Hrs. If Under 1 Year 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Days 381-20-3292 Months 1□M 20 F Director MICH Usual Residence of Decedent 10d. Inside City Limits 10a. Stata 10b. County 10c. City, Town or Location ahow the Medical Examiner must be notified at 1 Yes 2 □ No Director MARYLAND 10b. Citizen of What Country? 10a. Street and Number ò UE 2 / 5

13. Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 238 800 VEDERE Reme : 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - Amarican Indian, 11. Marital Status Black, White, etc. 72 hours efter 1 Yes 2 No If Yes, Give Year or Dates: 1 Navar Married 2 Married "natural", or 21215-0020 1 ☐ Yes 2/2 No Specify þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mentel Hygiene. marked other than Elementary/Secondery (0-12) College (1-4or 5+) CEPTIONIST DOCTOR'S OFFICE 10 +HGRADE Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Department of Heelth end Mentel Important: If Nem 27 Ie marked of any Injury or other traumatic evenance. (MN-UNKNOWN JEORGE YARGARET Pages 1 and 2 should 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 75. WOODINGTON RD. 20c. Location - City or Town, State LLIE RIEND 20b. Place of Disposition (Name of cematery, cremetory or other place) 20a. Method of Disposition Date Burial 2 Cremation 3 Ramoval from State CEMETERY 87-08-99 LANSDOWNE, MARYLAND 5 ☐ Othar (Specify) 4 Donation ZION 21. Signature of Fundral Service Lice 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTO, MO. 21217 23a. Part 1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physicien and s the buriel-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as e consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? P.0. 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? complation of cause of death? 1 ☐ Yas 2 ☐ No certificate of Vital or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Dinpatient edical Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 5 Pending investigation 1 Watural death. 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 1/2 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. å. 29b. Signatura and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) July tourth 30. Name and address of person who completed cause of death (Hern 23a) (Type, Print) Graham Religrave, M.B., Johns Hopkins Boyview Medical Center, 4940 Eastern Avenue, Ruttimore, MD 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rav 6/95

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middla, Last) 2. Data of Death Month **Physician** BARRETT MARGARET 10:37 JULY /Medical 4e Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner **Baltimore** Randallstown Northwest Hospital Center | H Under 1 Year | H Under 24 Hrs. | 8. Deta of Birth | 9. Birthplace (State or Foreign | Months | Days | Hours | Min. | Sept. | 15, 1910 | Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 K 225-14-3780 88 Director Usuel Residance of Decedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 Yas No notified Director Maryland **Baltimore** Randallstown 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 'natural', or flams 23s or 3724 Brice Run Road ; Apt. J 21133 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, atc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 🔼 No If Yas, Giva 1 Nevar Married 2 Married yland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 K Divorced White Year or Datas: Completed 15. Decedent's Education (Specify only highest grada completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiens. Other then "n Elementary/Secondary (0-12)
12th Grade College (1-4or 5+) Registered Nurse Hospital marked other 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental Clarence Joseph Fassett Ellen Green 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt. J 19a. Informant's Name/Ralationship (Type, Print) Patricia L. Rosales - Daughter 3724 Brice Run Road; Randallstown, Maryland 21133 Important: If Nam 27 Is any injury or other tra Baltimore, 20a. Mathod of Disposition
1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 20b. Place of Disposition (Nama of cematary, cremetory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Othar (Specify) Balto./Washington Crematory7/5/99 Laurel, Maryland 21. Signature of Funerel Sarvice Licensee 22. Nama and Addrass of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rear feiture. List only one cause on each line. **Physician** /Medical Immediata Causa (Final diseasa or condition resulting in death) Examiner Examiner physician and the burial-transit death certificate be executed Sequentially list conditions, if any, laeding to immadiata causa. Entar Undarlying Cause (Diseese or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): 55x 68760. Physician/Medical Dua to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 3 Probably 4 □ Unknown à 1 Yes 2 No FIBRILLATION bengis be ed b à Records, 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 20 No certificate 1 Yes 1 ☐ Yes 2 ☐ No of Vital I or Attending Physician: after death. Director: After this certific 25. Was casa rafarred to medical Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division 1 Natural 5 Pending 1 Yes 2 No Invastigation 2 Accidant 6 Could not be datamined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar es stated.

2 Medical Examiner: On the basis of examination and/or investination in my opinion death occurred at the time. 29a. Certifier (Check only one) Medical completely amilger: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. To the To the To the 29b. Signatura and titla of m 29c. License number 29d. Date signed (Month, Day, Year) MD D44501

State Registrar

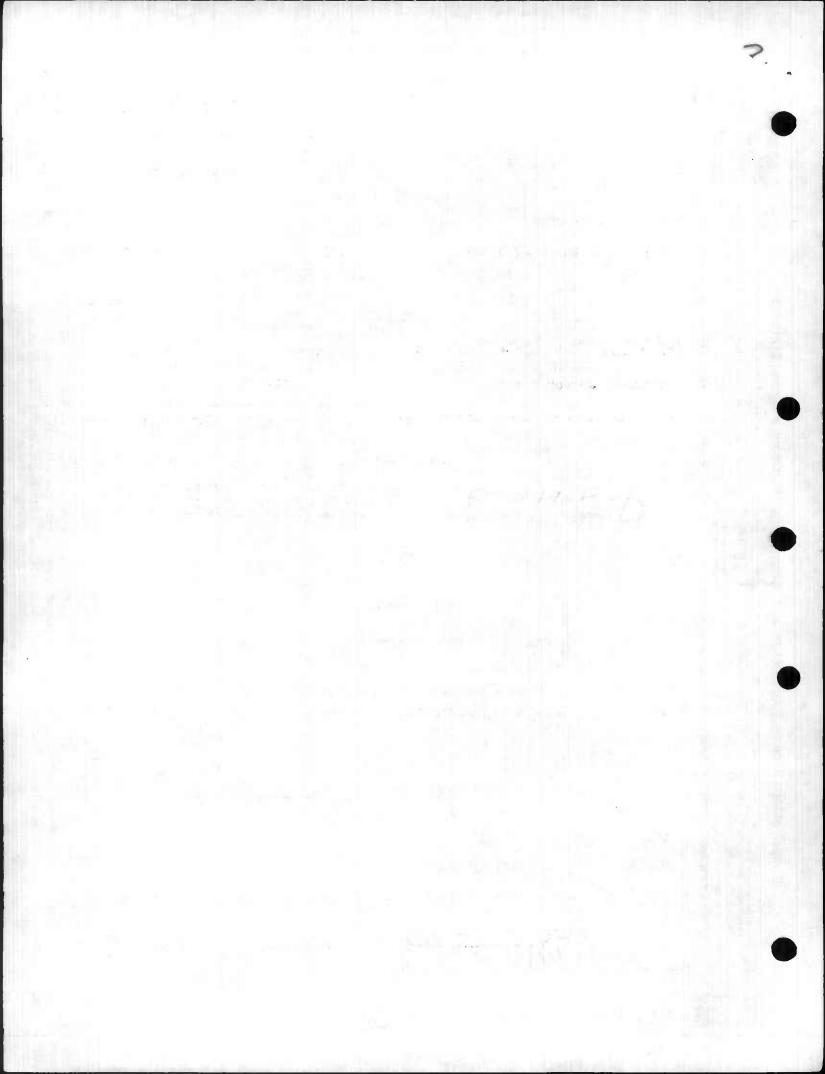
**DHMH 16 Rev 6/95** 

31. Data filed (Month, Day, Year)

30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

0 6/1999

32. Registrar's Signatura



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month YULY WZZ DW BARTKO CHESTER 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSP! TAL BAYNIEW BALTIMORE BALTHORE HOPKINS 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) N • Y • Days Months Hours 1X M 2□ F 76 214-14-7672 March30, Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d Inside City Limits 1 Yes XIXNo Md. Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7802 Wise Ave. 21222 USA 12. Was Decedent Ever in U,S. Armed Forces? DOM'es 2 □ No if Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Produce 12 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lubiniecki Pauline Michael Bartko 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7802 Wise Ave. Dundalk Md. 21222 Jane Bartko wife 20b. Piace of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Date July 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cem. 8,1999 Baltimore 22. Name and Address of Fecility 21. Signature of Funeral Service Licenses Connelly Funeral Home Of Dundalk 7110 Sollers Point Rd. 21222 onn Part 1. Erner the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part1. transdiate Cause (Final disease or condition resulting in death) BANIN HERNIATION MUE TO SUBRURAL HEMATOMA 5 DAYS Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy tindings 24a. Was an autopsy performed? available prior to completion of cause of death? 1 Yes 2 KNo 1 Yes 2 No 26. Piace of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner

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page 2

The law requires that the death certificate be executed

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72 hours after

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 27. Menner of Death

5 Pending investigation

6 Could not be determined

Anten

28b. Time of

Place of Injury - At home, ferm, atreet, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as atated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

(Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

/1 coman

1 Natural

2 Accident

3 Suicide

29e. Certifier

4 ☐ Homicide

29c. License number RES - 000 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) STIOW W. EPIN DOT MOINA 600

32 Registrer's Signature

M.D.

STREET . BALT IMORE

Registrar

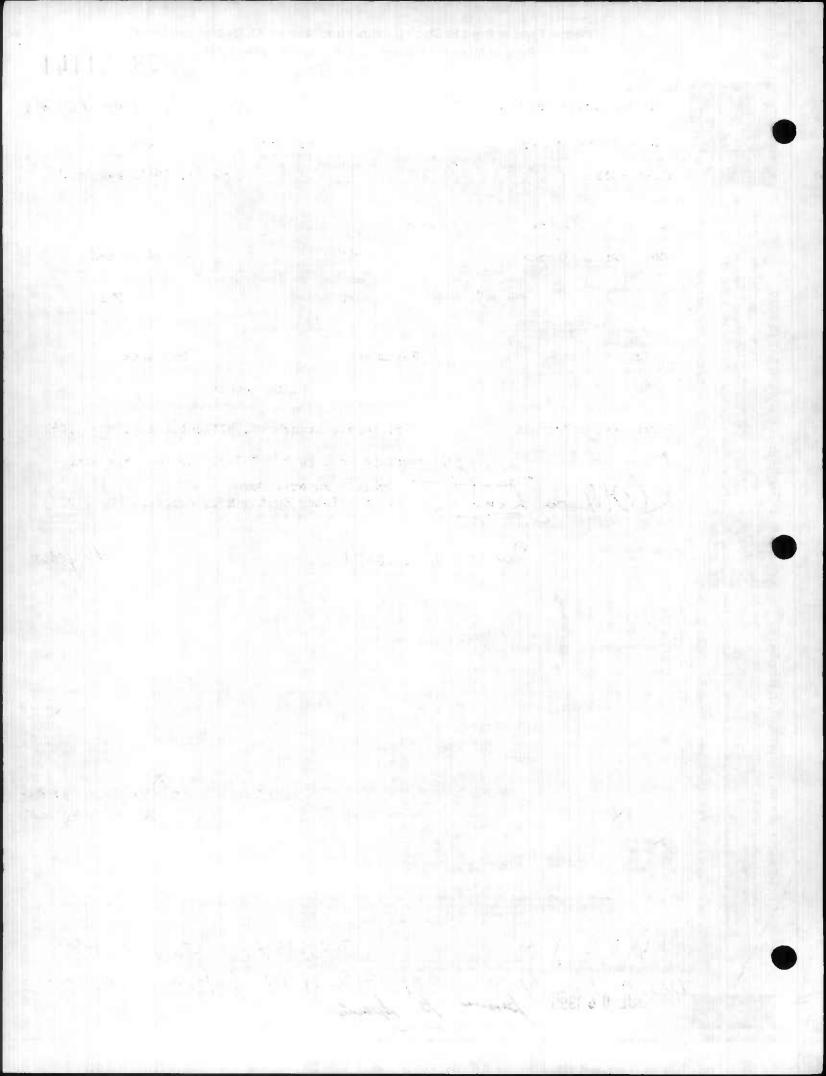
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month **Physician** Vivian Louise Barrett Jul /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Beath 4c. County of Death Examiner Stella Maris at Mercy Baltimore n/aIf Under 1 Yeer If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** Deys Hours 1 M 2 XF Yrs. 218-80-5198 Director 86 June 23, 1913 Maryland Usuel Residence of Decedent the Maryland r 28a-f show 10e Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director MD Baltimore Arbutus 10e. Street end Number 10f. Zip Code 10g. Citizan of Whet Country? with r than "natural", or items 23s or the Medical Examiner must be r 1001 Francis Avenue 21227 United States Pages 1 and 2 should be filed within 72 hours after death tent of Health and Mental Hygiena.
nt: If item 27 is marked other than "natures", or items 23. Funeral 14. Raca - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White à 3 ₩ Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elamentery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home traumatic avent. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be To John Ford Clara Becker 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Steta, Zip Code) other t 20b. Place of Disposition (Name of cametery, cremetory or other place)

20c. Location - City or Town, State Burke Lester Barrett 20e. Method of Disposition 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) 6 permit. Page Department of Important: If any Injury or pnce. 7-7-99 Meadowridge Mem. Park Dorsey, Maryland 22. Neme end Address of Fecility
Ambrose Funeral Home 21. Signatury'8t Funeral Seguce Licenseth 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Pert1. Enter the disease, or complication. Let shock, or heert feilure. List only one cause on each line. death. Do not enter the mode of dying, such es cardiac or respiretory errast, Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting in death) Examiner Due to (of as e consequence of): Examiner physician and the bunal-transit Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Ceusa (Diseese or Injury that initieted events rasulting in death) Last Due to (or es e consequença of) certificate be exer Division of Vital Records, P.O. Box 68760. Physician/Medicai Due to (or es e consequenca of) 88 use 0 signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably A Unknown by 24b. Were autopsy findings eveilable prior to 24e. Wes an autopsy Completed completion of cause of deeth? page 2 s 188 1 ☐ Yas 2 ☐ No certificate or Attending Physician: 25. Wes case raferred to medical examiner? 28. Plece of Daeth (Check only one) Stell A MARIS AT MERCI Be Other: 4 Nursing Home 5 Residence 8 Sother (Specify) HOSpice Hospitel: 1 Yes 2 No 0 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 27. Menper of Deeth 28d. Dascribe how Injury occurred 28b. Time of 28e. Data of Injury (Month, Dey Year) 28c. Injury et Work? After 1 Certification: 1 Neturel 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 Homicida 24 hours a Hospital Lertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier (Check only one) Medical completaly To the I within 2 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) M 30. Name end eddress of person who complated cause of death (Item 23e) (Type, Print)

State Registrar DERG

Registrar's Signetur



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JUNE 1999 11:30 A.M. FRANCIS WILLIAM BURKHARDT /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Dec. 20, 1915 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthpiace (State or Foreign **Funeral** Days Months Hours 212-01-4729 1 M 2□ F 83 Yrs. Mary Tand Director Usual Residence of Decedent 10a. Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at Maryland Anne Arundel 1 Yes X No Glen Burnie Directo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or flams 23a or 7846 Americana Court 21061 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marilal Slatus pamit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or its 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Commercial Sign Painter Commercial 17. Father's Name (First, Middle, Last) Frank Burkhardt 18. Mother's Neme (First, Middle, Meiden Sumame) Be Unknown 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Burdell (friend) 8150 Elizabeth Rd. Pasadena, Md. 21122 20b. Place of Disposition (Name of Hoteley, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1) Burial 2 Cremation 3 Removal from State b July 2, 1999 Glen Burnie, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Stallings Funeral Home, P.A. 21. Signature of Funeral Service Liji 3111 Mountain Rd. Pasadena, Md.21122 23a. Part1. Enter the disease, or complications a caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause of nace the. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel 2 months Churen disease or condition resulting in death) Examiner Examiner physician and s the burief-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequenca of) Box 68760, Physician/Medicai Due to (or as a consequence of) 980 detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 1 Yes 2 □ No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed peed page 2 s 1 Yes 2 DINO 1 ☐ Yes · 2 ☐ No certificate Division of Vital or Attending Physician: Be 25. Was case referred to medical exeminer? 26. Pleca of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending n 24 hours after death.

Ne Funeral Director: Aft pletely filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral Discompletely filled it 29a. Certifier 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and pieca, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 16 Rev 6/95

32. Registrar's Signature

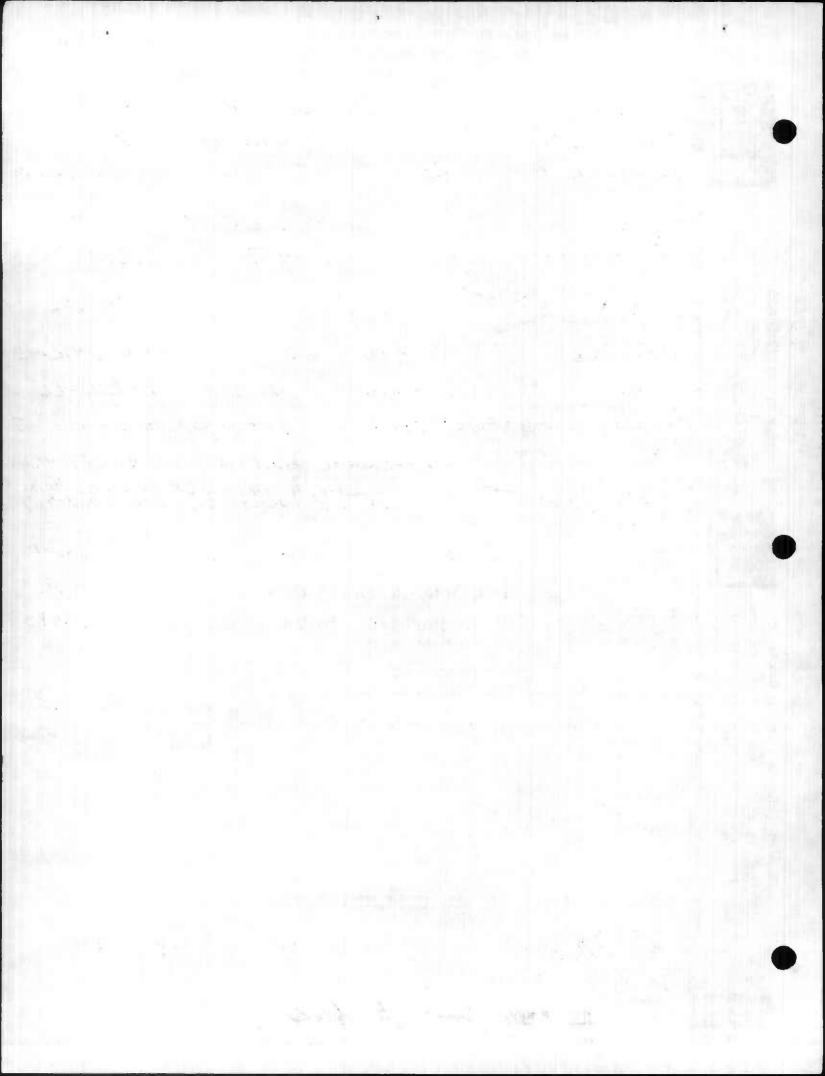
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #20b PER EH G773 7/9/99 AH Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Dorothy Souks 4:17 PM JU1, 3 1999 /Medical 4c. County of Death 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death Examiner of Balfimore Bultimore Sinai Hospital If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year 6. Sex 5. Social Security Number 7. Age (In yrs. lest birthdey) Birthplace (Stete or Foreign Country) **Funeral** 1 M 2 F Months Days Yrs. Director 214 20 7316 APR.7.1928 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other treumstic event, the Medical Examiner must be notified at 1 Yes 2 No Directo MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 0 238 5332 WINNER AVENUE 21215 U.S. OF A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 11. Marital Status 1 Never Married 2 Married 8 1□ Yes 2 No Specify: Specify: BLACK þ 3XWidowed 4 □ Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) UNKNOWN UNKNOWN NURSE HOSPITAL Dorothy 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) MARY PARKER OLIVER BROWN 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MONICA LUCIUS (DAUGHTER)
20a. Method of Disposition 5332 WINNER AVE. BALTIMORE, MARYLAND 21215 altimore, 20b. Placa of Disposition (Name of DRUID BIDGE cemetery, cremetory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) any injury or o WOODLAWN CEMETERY 7/9/99 BALTIMORE, MARYLAND 21. Signature of Funesai Service Licande IS T. LEWIS T. GWYNN FUNERAL HOME 21215-6393 **GWYNN** 4517 PARK HETGHTS AVE. Part 1. Enfer the disease, or complications of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Abdominal Antic Anergys 2 months Examiner Due to (or es a consequence of): Examiner Hypertensian ician and burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): of Anter Disease. Due to (or as a consequence of): Coronary 10 years Box 68760 physician Physician/Medicai the 88 957 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. 1 Yee 2 No 3 Probably 4 Wunknown Congestive Heart Failure Division of Vital Records, þ 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 2 No 1 ☐ Yes 2 XNo 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: After Hospital or Attending Neturel 5 Pendina after death. 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 154 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piace, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Fune completely fi (Check only one) the 29b. Signature and title of contilio 29c. License number 29d. Date signed (Month, Dev. Year) ompleted cause of death (Item 23a) (Type, Print) Sinas 31. Date flied (Month, Day, Year) 32. Registrar's Signature Registrar

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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Month 12:55 AM nomac ULL Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death County of Deeth Rehab & Nursing Center Burtonsville Time If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In vis, last birthday) (State or Foreign Sex M 2□ F Months Deys Hours -22-7826 Mary Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5108 010 12. Wes Decedent Ever in U.S. Armed Forces? 12 Yes 2 No 1947 Yes, Give Yeer or Detes: 195/ Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 Never Married 2 Married 1□ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 1951 16e. Decedent's Usuel Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lillian Bar Bar lilliam Informant's Name/Reletionship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is Cavey Zelay MI 20b. Plece of Disposition (Name of cametery, crematory of other) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removal from State Donetion 5 Other (Specify) 21. SignatOp of Funeral Service Licenses 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) 01 Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Bladder Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evellable prior to completion of ceuse of deeth? 24e. Wes en eutopsy performed? 2 No 1 ☐ Yes 2 No 25. Wes cese referred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide

Division of Vital Records, P.O. Box 68760

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Baltimore, Maryland 21215-0020

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29a. Certifier (Check only one)

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2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) end manner steted. 29b. Signeturi and Hill

29c. License number

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#20b,20c perFH G773 7/9/99 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30 **Physician** JULY-04-1999. /Medical 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street end number) 4c. County of Death Examiner 5. Social Security Number rore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 6 Sex 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Country) **Funeral** Months Days Hours 1□ M 2□F 224-44-2548 Usual Residence of Decedent Yrs. Director May 28:1936 the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryle ment of Health end Mental Hygiene.
snt: if item 27 is marked other than "natural; or items 23a or 28e-f show ury or other traumatic event, the Modical Examinating mantle is notified as BALTIMORE 1 PYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45A 1640 EllamonT 21216 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married Specify: Africian American 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0020 py 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 Th 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fsther's Name (First, Middle, Last) Be 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) DENIE15 Elfamont Street BALLimore, MD. 21216 Hichie 1640 N. 20b. Place of Disposition (Name of cametery, cremetory or other place)
Woodlawn cemetery Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or pnce. 4 ☐ Donation 5 ☐ Other (Specify) July 10,1999 22. Name and Address of Fecility Albert P. WYLie 21. Signature of Funeral Service Licensee 23 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest,

Approximate shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting In deeth) Examiner Examiner perhue physician and the burial-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Mycal ension Physician/Medical Due to (or as e consequence of): 65 use 23b. Did tobacco use contributs to the causa of death? Part II. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part f. t ☐ Yes 2 No 3 Probably 4 Unknown signed t by 24b. Were autopsy findings available prior to Completed 24e. Was an eutopsy completion of cause of death? page 2 20 No 1 ☐ Yes 2 ☑ No 1 Tes certificate or Attending Physician: funeral director, 25. Was case referred to medical axaminer? 26. Plece of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 11 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Mannerof Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Netural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined To the Hospital or Atterwithin 24 hours after der To the Funeral Director completely filled in by the 3 Sulcide Location (Street and Number or Rurel Route Number, City or Town, State) Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier edical 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifier ani

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30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** 6:50 A.M. EVA Dowd 0 02 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Glen Koch Nursing Center Baltimore If Under 1 Year
Months Deys 8. Date of Birth (Month, Day, Year) 10-28-11 If Under 24 Hrs. Hours Min. 5. Social Security Number 8. Sex 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign NEW YORK **Funeral** 1□ M 2XF Months 228-28-1404 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Medical Examinar naust be notified at BALTIMORE MD N/A 1 Yes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 0 U.S. OF 21215 Α. 234 3508 ELLAMONT ROAD Funerai 2 should be filed within 72 hours after deeth in end Mentel Hygiene.
Is marked other than "natural", or items 23: 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Biack, White, etc.
BLACK 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2 No Specify: þ 3 Widowed 4 □ Divorcad Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry  $\begin{array}{c} \text{Elementary/Secondery (0-12)} \\ 12TH \end{array}$ U S. GOVERNMENT LIBRARIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be MARY J. WASHINGTON ROBERT F. WASHINGTON 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) permit. Peges 1 end 2 st Department of Health enc Important: If Item 27 Is n any Injury or other traun once. BALTIMORE, MARYLAND21215 3401 ELLAMONT ROAD MRS. CLARA JONES (FRIEND) 20b. Place of Disposition (Name of cemetery, cremetery or other place) 7 / 8 / 9 9 Dete 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriai 2 ☐ Cremation 3 ☐ Removal from Stete POUGHKEEPSIE RURAL CEM. POUGHKEEPSIE N Y. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Ineral Service Licensed LEWIS T. GWYNN<sup>22</sup> Name and Address of Facility NN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVE. ymu 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, auch as cardiac or respiretory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediete Cause (Finei disease or condition resulting in death) 480 Sepsis Examine Due to (or es e consequence of): Examiner of bungrene Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of) Division of Vital Records, P.O. Box 68760 attending physician for use es the buria Due to (or es e consequence of): Vascula or Attending Physician: The lew requires that the death certificate be Physician/Medical that initiated events resulting in death) Lest Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was en autopsy performed? certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how Injury occurred 28c. Injury at Work? After 5 Pending investigation Natural death. 111 NIAM 1 Yes 2 No 2 Accident 1/2 ofter death Director: / 6 Could not be 3 Sulcide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, State) 4 Thomicide 24 hours eft e Funeral Di detely filled in 214 NIA 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) end menner as stated.
2 Medical Examinar: On the bests of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and vite of 29c. License number 29d. Date signed (Month, Dey, Year) 7.6.1999 743386 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 5t. - Suite 405 N. Erku Hound Bullinere uno 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dev **Physician** 3;30 A.M. ROBERT O DENMYER SR.

4a Facility Neme (If not institution, give street and number) July 3
4b. City, Town, or Location of Death 3,1999 /Medical 4c. County of Death Examiner Lot # 35 Finksburg Carroll 2201 Old Westminster Pike (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) June 17,1926 9. Birthplace (State or Foreign **Funeral** Months Deys Hours 1₩ 2□ F Balto. Co. Md Yrs. 73 Director 219-18-9337 Usual Residence of Decedent 10c. City. Town or Location 10d Inside City Limits 10e Stete 10b. Counts the Maryta 1 Yes 2 No Md. Carroll Finksburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iner must be n USA 2201 Old Westminster Pike Lot # 35 21048 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygione. Important: if item 27 is marked other in any injury or other transitied other in 25. 12. Wes Decedent Ever in U,S.
Armed Forces?

1 M Yes 2 □ No
If Yes, Give
Year or Detes: 44-45 14. Race - American Indian, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Landscaping Self Employed 8 th Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Emma Heilman Harry L. Denmyer 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2201 Old Westminster Pike Finksburg, Md. 21048 (Wife) Mrs. Audrey E. Denmyer 20b. Piaca of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Durlal 2 Cremation 3 Removal from State 7/6/99 Cockeysville, Md. Dulaney Valley Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Line 22. Name and Address of Facility 11824 Reisterstown Road 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ELINE FUNERAL HOME Reisterstown, Md. 21136 **Physician** LY MPHOMA Immediate Cause (Final disease or condition resulting in death) /Wediçai Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be axecuted physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 986 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy has e 2 s certificate ha 1 Yes 2 THO 1 Yes 2 W Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Pestdenca 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Dete of Injury (Month, Dey Yeer) 28d. Describe how Injury occurred 28c. Injury at Work? Certification: or Attending s after dec. 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hour.
The Funeral Direction by 4 | Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi 29d. Date signed (Month, Day, Year) 29b. Signatur eddress of person who completed cause of death (Item 23a) (Type, Print) yestmenster MD 2115 Washington Heights State

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Registrar

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### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DUNCAN Month ~ 2 Am YNN AMBER 1999 JULY 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death College Avenue Ellicott City Howard H Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months Days 1□ M 2⊠ F 17 Yrs. 214-19-0798 May 2, 1982 Maryland Usual Residence of Decedent 10a State 10b. Counts 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 No MD Baltimore Woodlawn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2110 Northland Road 21207 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☑ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Student NONE 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wayne Duncan Anne Levering 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Liberto (Steph-Father) 2110 Northland Road, Woodlawn, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Stete Loarraine Park Cemetery 7/7/99 Woodlawn, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licensee 1630 EdmondsonAvenue, Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Head Massive se conds vaum A. disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 PNo 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Mother (Specify) road ride 1 Yes 2 No 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation motor vehicle hit tree

1 Yes 2 DN6

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4565 HEM LOCK LONE WAY

29c. License number

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**Physician** 

/Medical

Examiner

**Funeral** 

Director

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pemit. Pages 1 and 2 should be filed be partment of Health and Mental Hygic Important: If Itan 27 is marked other 1 any injury or other traumatic avantment.

Physician /Medical

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Certification:

Medical

Saltimore, Maryland 21215-0020

certificate Mospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica director,

**DHMH 16 Rev 6/95** 

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> State Registrar

31. Date filed (Month, Day, Year) 0 6 1999

29b. Signature and title of certifier

2 Accident

4 ☐ Homicide

(Check only one)

PATRYCE

3 ☐ Suicide

29a. Certifier

6 Could not be determined

32. Registrar's Signature

TOTE, MY

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

A.

July 3, 1999

roadside

2 A

N

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

mo

**ORIGINAL** 

29d. Date signed (Month, Day, Year)

ollege Avencar Bonnie Br

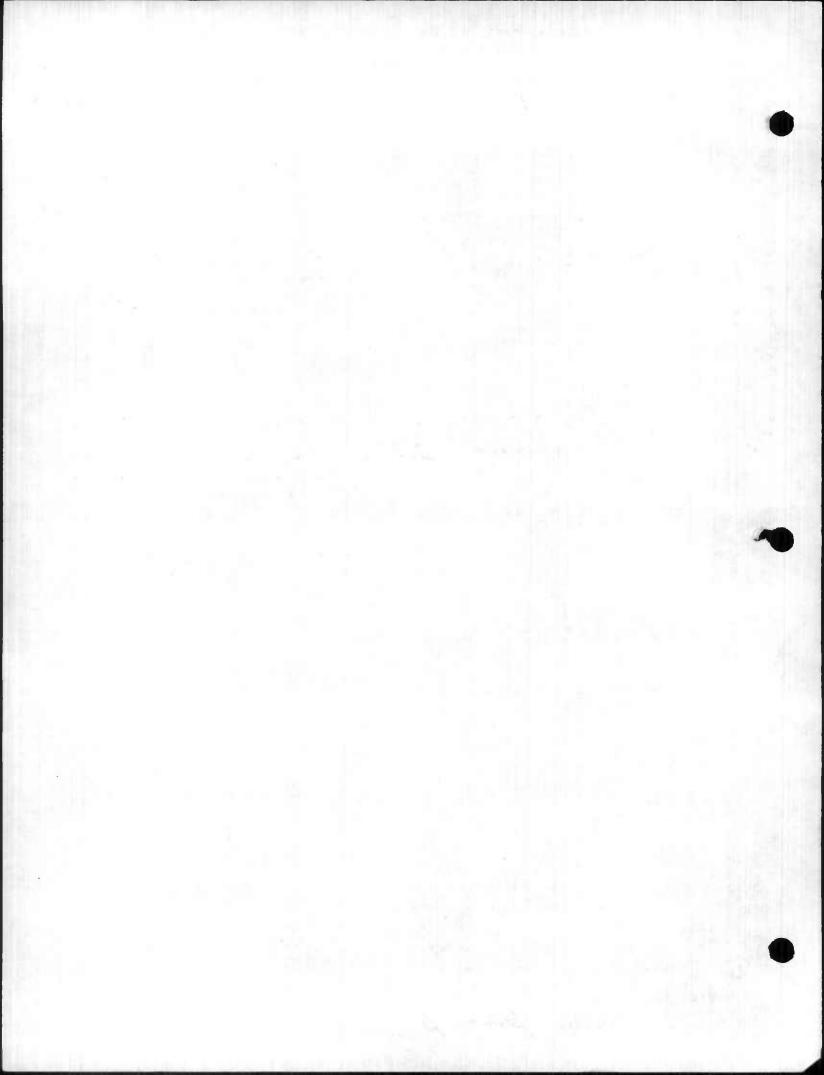
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Wedical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3, 1999

21042

ELLUCOTTCTY



32. Ragistrar's Signature

Registrar

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31. Data filed (Month, Day, Year)

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Robert Rener Manuel Se.

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Susanne M. 19Misen - 1820 - 1920 decree hill Re., Swinter Hills, 24.

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#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 1. Decedent's Nema (First, Middle, Last) 3, 1999 Andrew Epsilantis July 7:26 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Future Care Old Court Randallstown Baltimore 6. Sex 1 ☑ M 2 ☐ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) Days Months Hours Yrs. 69 220-24-2110 Oct.3, 1929 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland Anne Arundel Glen Burnie 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 Washington Blvd 21061 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1X Never Married 2 Merried 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) 12 College (1-4or 5+) Butcher Retail Sales 17. Fathar's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Nicholas Epsilantis Anna Mugolis 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Daphne Bratt (Sister) 303 Washington Blvd. Glen Burnie, Md. 21601 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stata: Metro Crematory Inc. 7/5/99 4 Donation 5 Othar (Specify) Baltimore, Md. 22. Name end Address of Fecility 21. Signature of Funeral Service Licens Stallings Funeral Home PA 3111 Mountain Rd. Pasadena. Do not enter the mode of dying, such es cardiac or respiratory arrest, Md. 21122 Approximate Interval Between Onsat and Death Immediate Cause (Final Artersosclerotre cardovascular disesse disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Ysa 2 ☐ No 3 ☐ Probably 4 Ø Unknown serpheral vascular d. 24b. Were autopsy findings available prior to complation of cause of deeth? 24a. Was en autopsy performed? necrotic ulcers and wheetrom 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide

Records, The Division of Vital Hospital or Attending Physician: 24 hours efter death.
 Funeral Director: After this certifical eletely filled in by the funeral director,

P.O. Box 68760

Physician

/Medical

Examiner

**Funeral** 

Director

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natural, or

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Pages 1 and 2 should be nert of Health and Mental ant: If them 27 is marked of

Department of Health ar Important: If Iham 27 is any injury or other trea once.

**Physician** /Medical

Examiner

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Physician/Medicai

Completed by

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Certification:

Medical

29a. Certifier

(Check only one)

29b. Signetura and titia of certifier

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Baltimore, Maryland 21215-0020

Directo

Funeral

Completed

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State Registrar

DHMH 16 Rev 6/95

To the Hosp within 24 ho To the Fune completely fi

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29d. Data signed (Month, Day, Year) 35844 1999 05

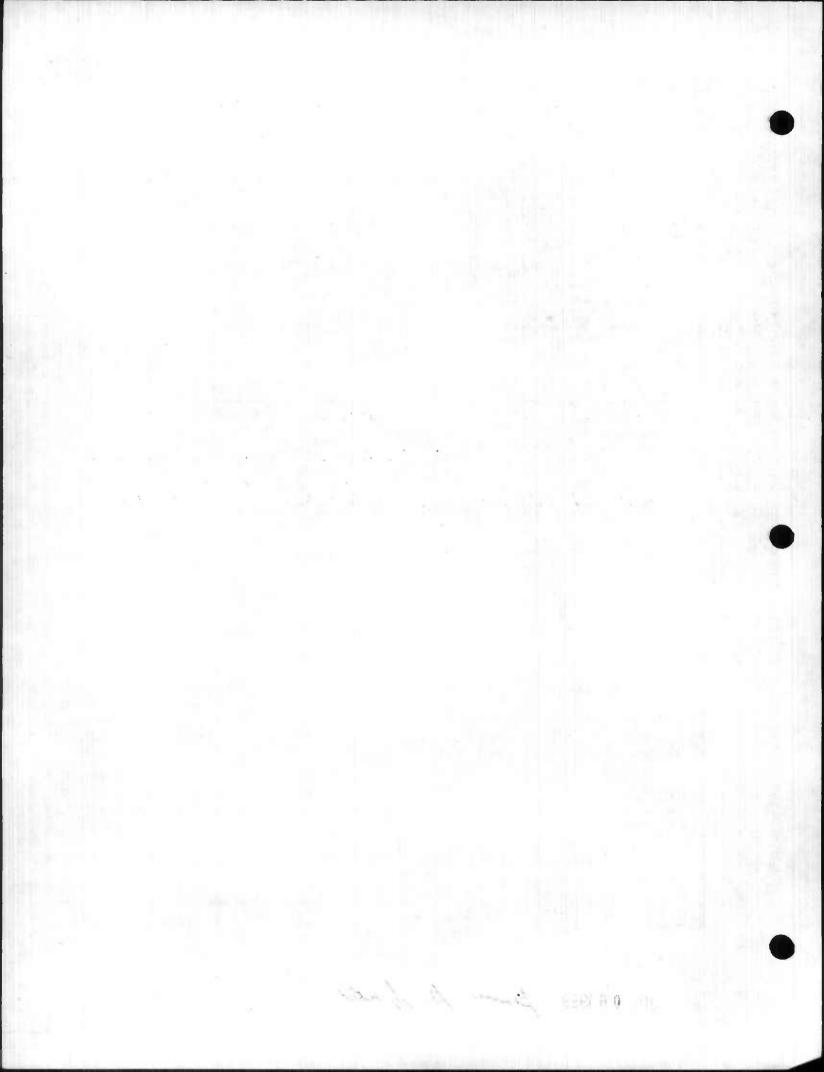
30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Randallstown

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month JU/4 Physician MARY GETROST 1999 1320 /Medical 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia If Under 24 Hrs. Howard If Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. Months Deys 1 M 200F 271-26-1339 70 **Director** Jan. Ohio Usual Residence of Decedent 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits ahow Howard Columbia 1 ☐ Yes 2 ₺ No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ð 10321 Day Star Court U.S.A. 14. Rece - American Indian, Bleck, White, etc. "natural", or Norse 23s 21044 Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give pamit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hypische. Proportent: if them 37 is marked other than "natural; or he any injury or other traumatic event, the Medical Examine any injury or other traumatic event, the Medical Examine. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 specify: White 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 💆 Divorced Year or Detes: Completed 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Administrative Assistant Health Care 4 17. Father's Neme (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Walter Lacock Eva Neville 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracey Getrost (Daughter) 5362 Smooth Meadow Way, Columbia, MD 21044 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Balto. Wash. Crematory 7/5/99 Laurel, Maryland 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Witzke Funeral Homes, Inc. 5555 Twin Knolls Way, Columbia, MD Lemmer 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical tmmediate Cause (Final disease or condition resulting in deeth) Obstoructive Polmonary disease Examiner Examiner timillATIU physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, teeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated avents resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 980 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes an eutopsy performed? Completed 2 0 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3□ DOA 1 Inpatient this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Neturel To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 1 □ Yes 2 □ No 2 ☐ Accident 8 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. (Check only one)

Registrar

29b. Signeture and

31. Dete fited (Month, Dey, Year) JUL 0 6 1999

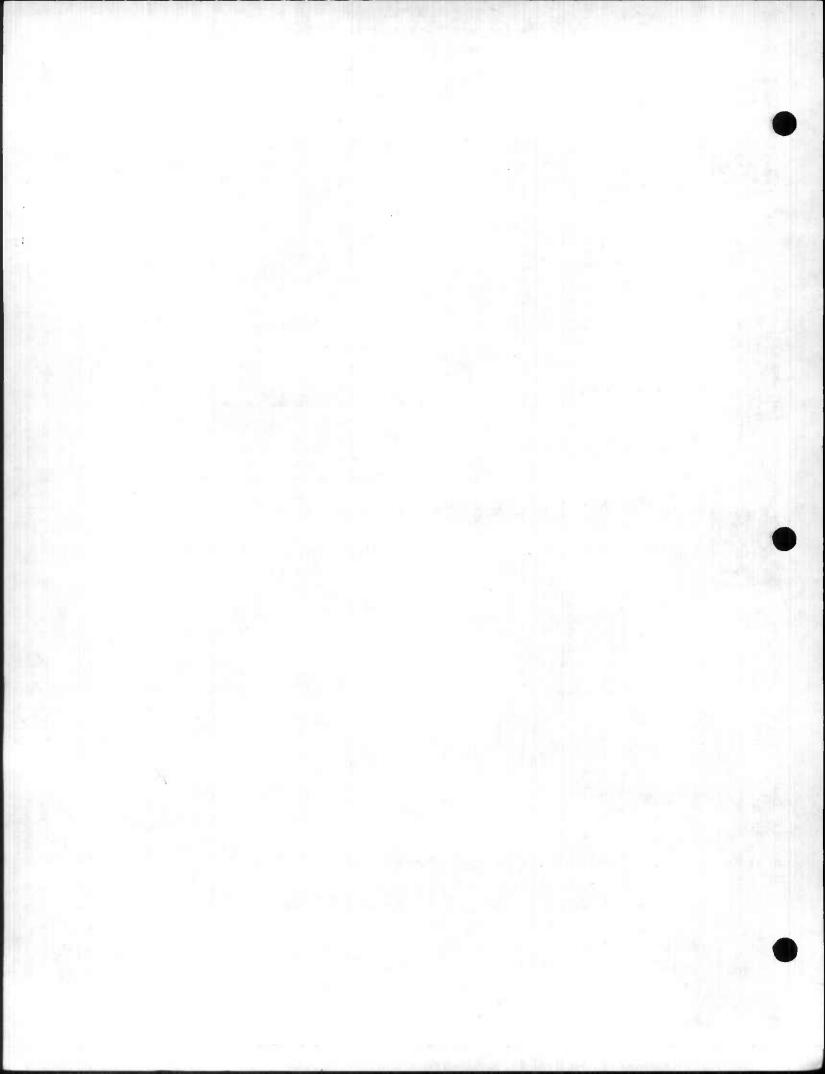
30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

EKNOIL NORTH DV. Columbia MD 32. Degistrer's Signeture

29c. License number

29d. Date signed (Month, Day, Year)

William SAMMY



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death GETTIER Month Day 11:16 DM July 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death 608 Carrollwood Rd., Apt. E Baltimore **Baltimore** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Deys Months Hours 1□ M 25 F 216 34 1590 61 Yrs. Feb. 21,1938 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Baltimore 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 608 Carrollwood Rd., Apt. E 21220 United States 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yes 2 No Spacity: Specify White 3XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16h Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Domestic Homemaker 10 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Meiden Surneme) Charles Baublitz Leroy Dorothy Beatrice Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code) Mary E. Hensley / Daughter 608 Carrollwood Rd., Apt. E, Baltimore, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Green Mount Crematory 7/3/99 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA Stephen D. LohrmannP.A. 8717 Green Pastures Dr. Baltimore, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death metastatic small cell lung cancer Immediate Cause (Final disaasa or condition resulting in death) Due to (or es e consequence of): Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Was an autopsy 1 ☐ Yas 2 12 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examinar? Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident

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**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

**Director** 

Item 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Medical Example must be nothed at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mentel Hygiene.
Important: if item 27 is marked other than "natural, or item any injury or other traumatic event, the Medical Examinations."

**Physician** /Medical

Examiner

altimore, Maryland 21215-0020

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death

Examiner Physician/Medical p Completed Be 10 funeral Certification:

Records, Division of Vital Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica n 24 hour.

> State Registrar

edical

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifian

6 Could not be

0 6 1999

MO

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

29c. License number 022782

1D Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the ceuse(s) end menner es stated.
2 Medical Examinar: On the best of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Dey, Year)

July 2, 1999

28f. Location (Street and Number or Rural Routa Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

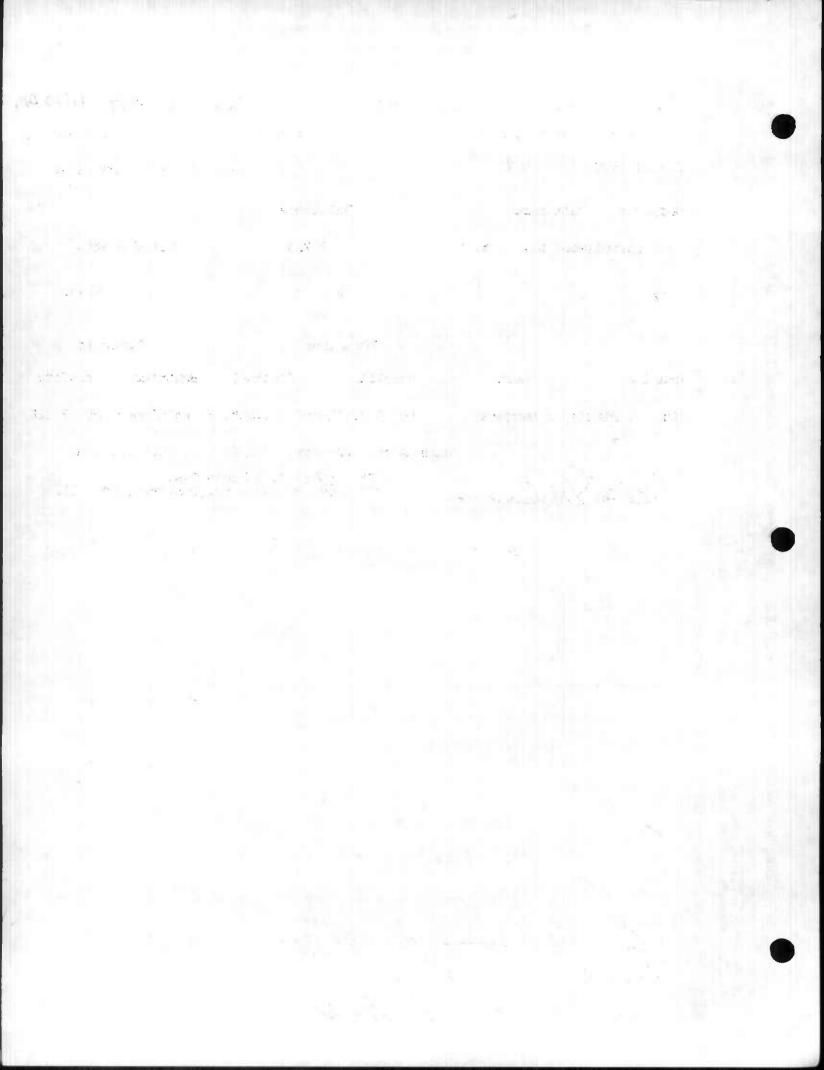
rkman mo 31. Date filed (Month, Day, Year)

32 Registrer's Signature

Hospital Center

**DHMH 16 Rev 6/95** 

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### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death Month 3. Time of Death June Arthur 23:01 Garde 30 1999 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death HOSPITO HOPKINS Battimore The Johns H Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) NOV. 27, 19 6. Sex 1 M 2 □ F If Under 1 Year 5. Social Security Number Birthplace (Stele or Foreign Country) 7. Age (In yrs. last birthday) Days Months 66 219-28-1252 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. Stata 10b. County 10d. Inside City Limits Maryland Pasadena Anne Arundel 1 Yes 2 No 10f. Zip Code 21122 10g. Citizen of What Country? 10e Street and Number 3502 Kingsley Court Apt. B USA 14. Reca - American Indian, Black, White, atc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specity: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Road Maintenance Public Works 18. Mother's Name (First, Middle, Maiden Sumema) 17. Father's Name (First, Middle, Last) Wilbur H. Garde Lillian Bouchat 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary K. Garde (wife) 2502 Kingsley Ct. Apt. B Pasadena, Md. 21122 20b. Plece of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20e. Method of Disposition 1X Burial 2 Cremation 3 Removel from State Cedar Hill Cemetery July 5, 1999 Brooklyn, Md. 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service License 22. Neme end Addréss of Facility Stallings Funeral Home, P.A. 3111 Mountain Road Pasadena, Md. 21122 23a. Part 1 Enter the disease, of complications that caused it shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final ACUTE MYOCARDIAL INFARCTION 4 hours disease or condition resulting in death) Due to (or as e consequence of): Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco usa contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. Unknown 1 | Yas 2 | No 3 | Probably 24a. Was en eutopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Watural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner physician and the burial-transit certificate be executed Box 68760. Physician/Medical 88 188 Records, P.O. by peed certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

**Physician** 

/Medical

Examiner

**Funeral** 

**Birector** 

28a-f ahow

the Medical Examiner must be notified at

'natural', or items 23s or

Hygiene.

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Department of Important: If any injury or once.

**Physician** /Medical

Examiner

Director

Funeral

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Completed

Be

with the Maryland

death

filed within 72 hours after

Baltimore, Maryland 21215-0020

Completed Be Certification: To edical

29e. Certifier

(Check only one)

State Registrar DHMH 16 Ray 6/95

DAVID E. KAPCAN, MO, 31. Date filed (Month, Day, Year) JUL 0 6 1999

29b. Signature and title of certifier

600 H. WOLFE ST. TOWER 32. Registrer's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BACTIMORE, MD 21287

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated.

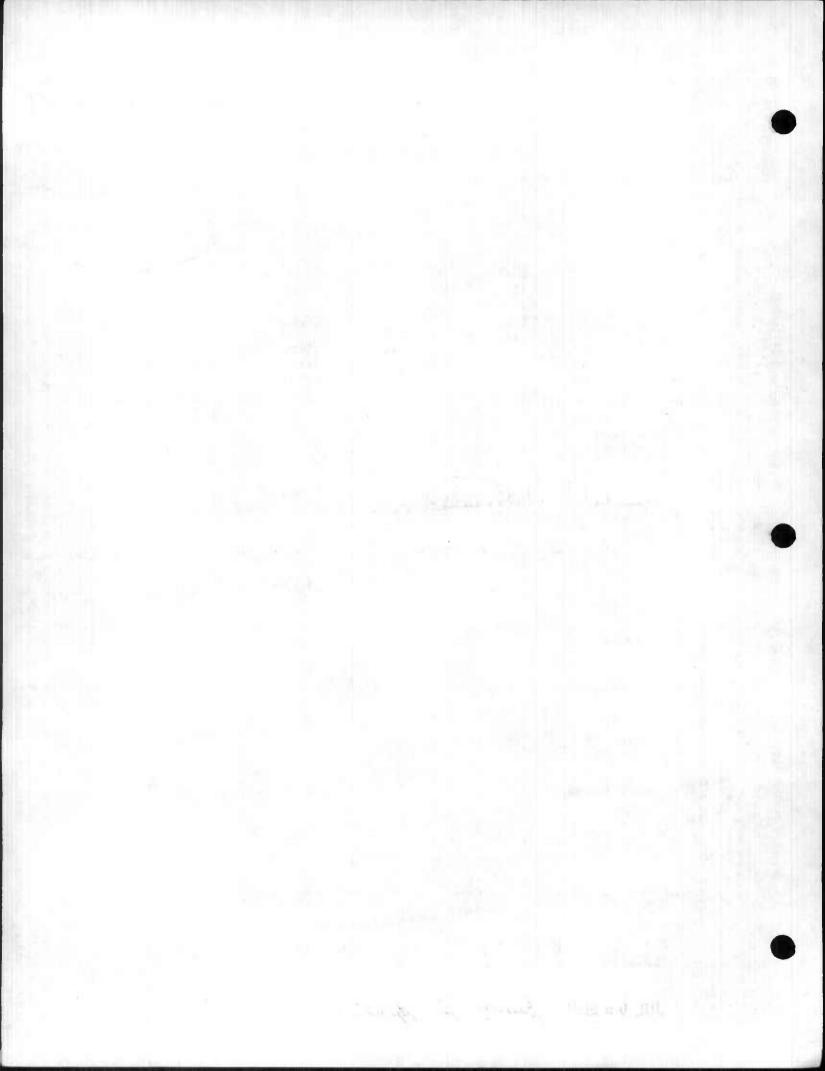
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the ceuse(s) and manner stated.

29c. License number

RES - 000

29d. Date signed (Month, Day, Year)

30, 1999



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0 Division of Vital Records. To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: After completely filled in by the fur

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31. Date filed (Month, Day, Year) 0 6 1999

29b. Signature and title of certifier

J-Chuteno 32. Registrar's Signature

ed cause of death (Item 23a) (Type, Print)

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Penn Street, Baltimore, Maryland 21201

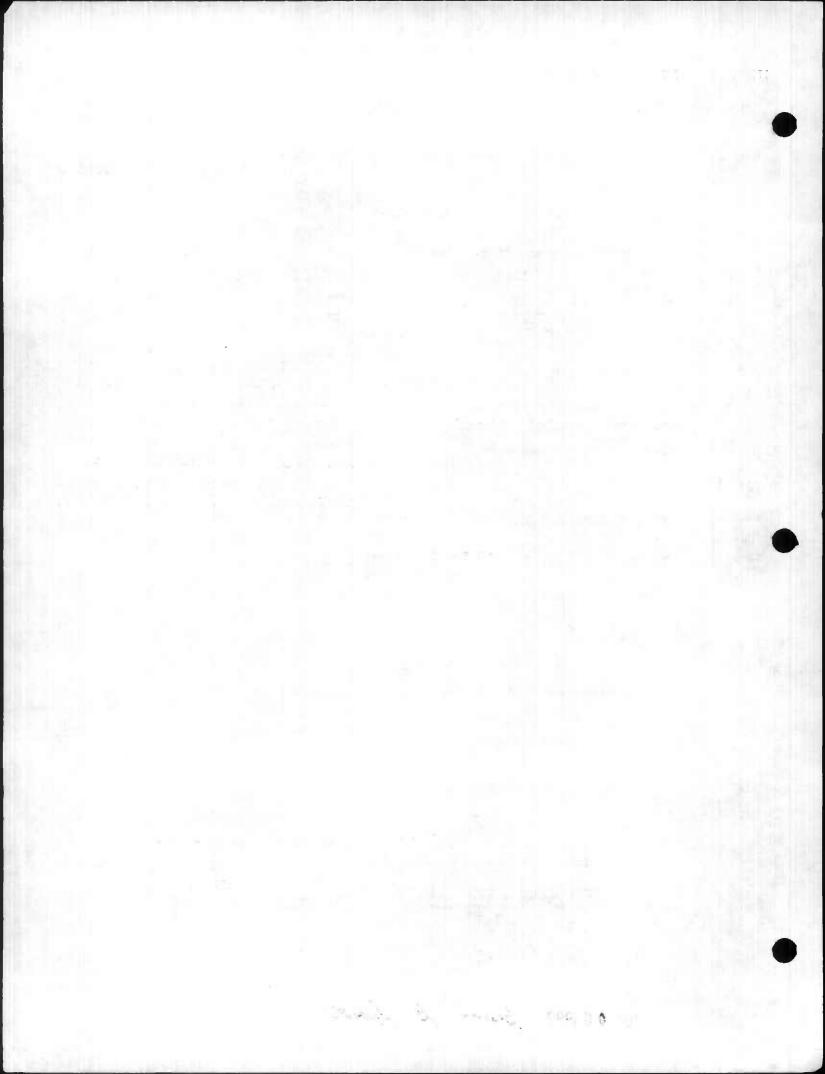
29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 01, 1999

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Ruth Holley F MMa 30 1999 10:350m JUNE /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAINT BALTIMORE AGNES HOSPITAL If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) If Under 1 Year 6 Sex 7. Age (In yrs. lest birthdey) 5. Social Security Number 9. Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Days Md 220-22-2788 Yrs. Director Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 Yes 2 □ No Baltimore Md WA Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "naturel", or itema 23a or 3401 U.S.A Mondawmin 21216 Grenne Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Detes: 14. Race - American Indian Wes Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus Black, White, etc. 1 Never Married 2 ☐ Married 1□ Yes 2 No Specify: Specify: Black by 3 Widowed 4 □ Divorced Completed ? Is marked other than "nature traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) (Specify only highest grede completed) Monumental hite Secondary (0-12) Coilege (1-4or 5+) chnician Insurance company 12th grade NA 18. Mother's Name (First, Middle, Meiden Sumsme) 17. Fatner's Name (First, Middle, Last) Be Van handingham Claron Ruth M 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Coda) 3/33 Item 27 is other tra Blud Ba Josephine 20a. Method of Disposition Windson 140, md 21207 Daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State ortant: If I important: If eny injury o poce. Woodlawn Cenetery Balto 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Sabrulle Cook Harch F. H. West Avenue Balto, rue zuss

23a. Part 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate 22 Name and Address of Facility Approximate Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final . CORONARY ARTERY DISEASE disease or condition rasulting in death) YEARS Examiner Due to (or as a consequence of): Examiner PNEUMONIA WEEKS physician and the burief-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) PERIPHERNL UASCYCAR VEARS Physician/Medicai Due to (or as e consequence of) ettending ph for use es ti OBSTRUCTIVE PULMONARY PISEASE CHRONIC YEARS signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobscco use contribute to the cause of death? 1 Yes 2□ No 3 Probably 4 Unknown HYPERTENSION 2 24b. Wara autopsy findings evailable prior to completion of cause of daath? Completed 24a. Was an autopsy performed? DIABETES MECCITUS. certificate hes t irector, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No director. Be 25. Was cese raferred to madical 26. Place of Death (Check only ona) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Tima of 28d. Describe how Injury occurred After 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homleide 24 hours a 1 Certifying Physicisn: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted 29a. Certifiar Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Msdlcaf Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760, MMM

The law requires that the death certificate be executed

or Attending Physicien:

death.

with the Meryland

Peges 1 and 2 should be filed within 72 hours efter death tent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

State Registrar

BOY (ADEU MICHAEL, ST' AGNES MOSPITH, BALTIMORT, MARTLAN
1. Date filed (Month, PRI) YORK & 1000 32. Register States S. Sporks 31. Date filed (Month, Day Year) 6 1999

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

1 BOTIADTUS MICHAEC

29b. Signature end title of certifier



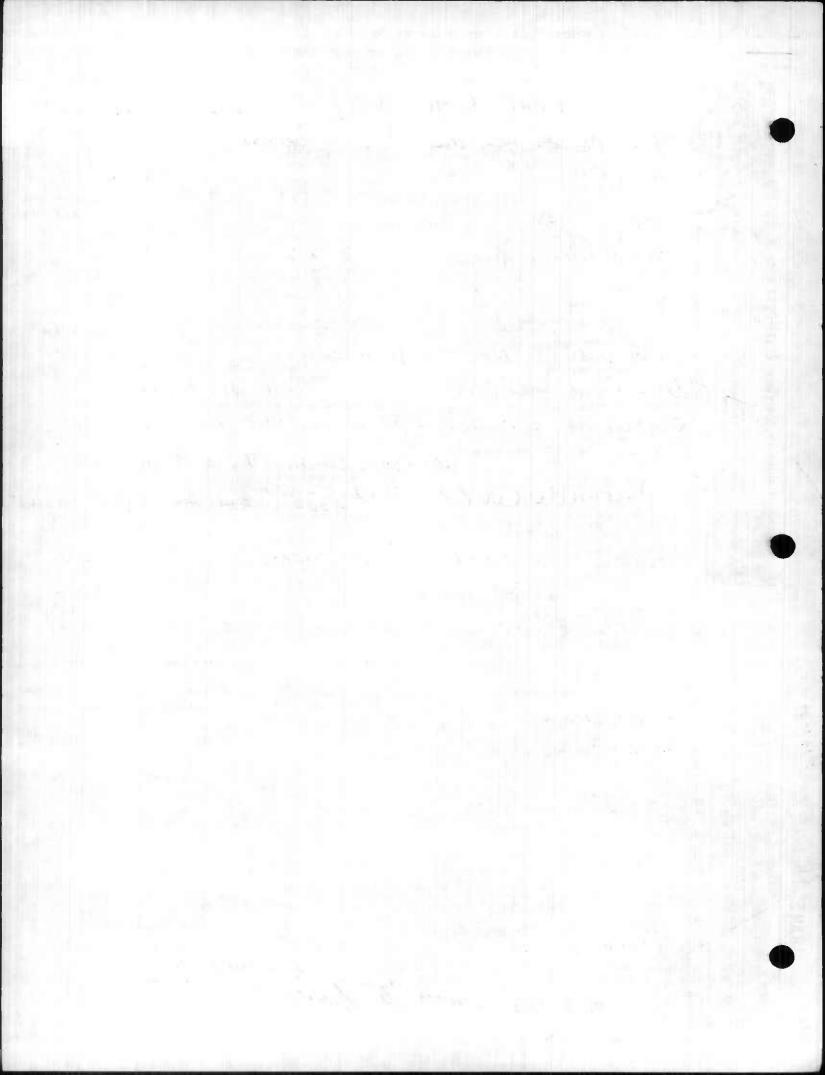
MEDICAL RESIDENT.

29d. Dete signed (Month, Day, Year) 30 14 N 1993.

900 CATON AVENUE

29c. License number

P12588



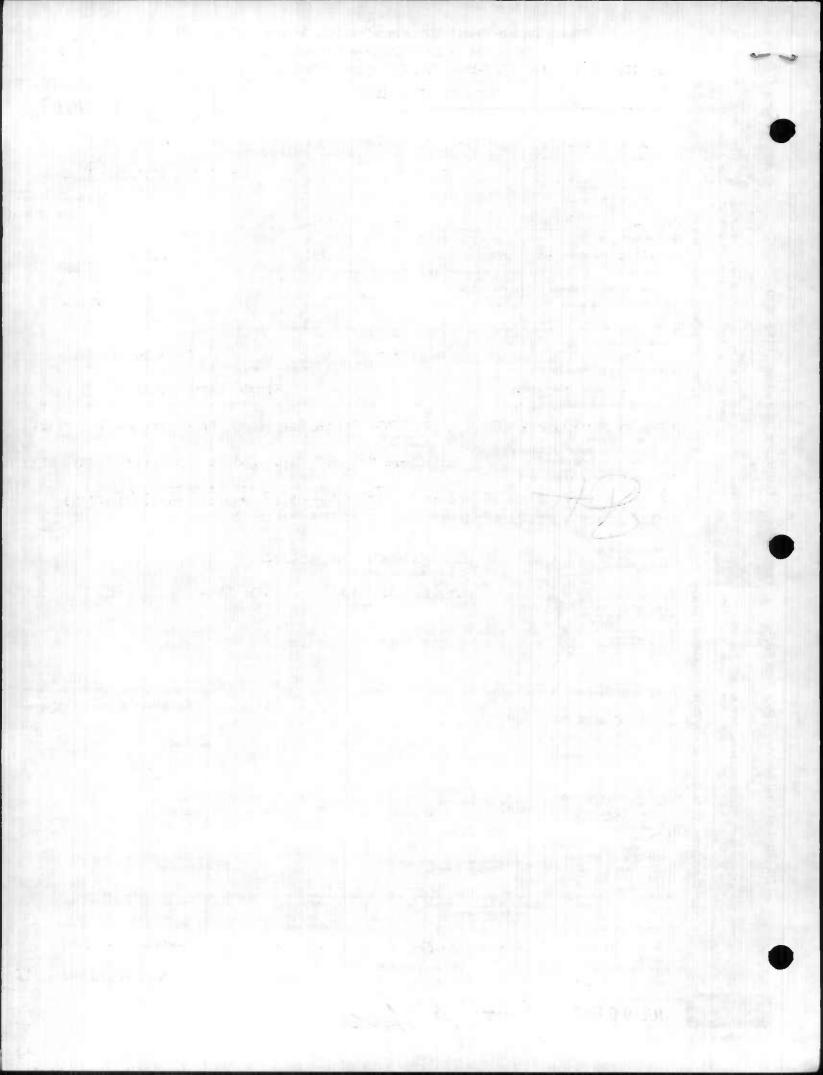
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM #1 PER PHYNS G773 7-15-99 J.A. Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death MARY MARGARET HURDEL Month **Physician** MARGARET 1408 Jule 1999 /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTER Bastimore NORTHWEST HOSPITAL KaudallsTown If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF Yrs. 87 215-03-1202 Director March 11, 1912 Maryland Usuel Rasidance of Dacedant permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiena. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other treumetic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☒ No Frederick Director Maryland Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11401 Beaver Dam Road 21791 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 14. Rece - American Indien, Black, White, etc. 11. Merital Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Nidowed 4 Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Coliege (1-4or 5+) 8 Waitress Town House Rest. 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Joseph Gumpman Sarah Mary Roberts 19e. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) Paul S. Hurdel, Jr. 11401 Beaver Dam Road Union Bridge, MD 21791 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑Buriai 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 Other (Specify) Baltimore National Cem. July 6, Baltimore City, MD 22. Neme end Address of Facility Funeral Directors, Inc. Loring Byers . Wayne Osterling 8728 Liberty Road Randallstown, MD complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate tntervel Between Onsat and Death **Physician** /Medical Immediata Causa (Final diseese or condition resulting In death) PULMONARY EMBOLUS Examiner Dua to (or as e consaquence of): Examiner DEEP VENOUS THROMBOSIS physician and the burial-transit tha daath certificata be axecuted Sequentially list conditions, if any, laading to immediate ceuse. Entar Underlying Ceusa (Diseasa or Injury that initiated evants resulting in death) Lest Due to (or es a consequance of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): usa as signed by tha a Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 Unknown 1 ☐ Yss 2 ☐ No LYPER KALEMIA p 24b. Wera eutopsy findings aveileble prior to 24e. Wes en autopsy performed? Completed completion of ceuse of deeth? paga 2 has 2 No 1 ☐ Yes 2 ☐ No cartificata or Attending Physicien: director 25. Was cese rafarred to medical examiner? 26. Place of Deeth (Check only ona) Hospitai: 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) To 1 Yes 2 No 28e. Date of Injury (Month, Dey Year) funeral 27. Manpar of Deeth 28d. Dascribe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: Aftar 1 Naturat 5 Pending aftar death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) Ptece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledga, daeth occurred et the time, dete end plece, end due to the cause(s) end menner as steted. 29a. Certifier To the Hosp within 24 hou To the Fune complataly fi edical (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daeth occurred at the time, date end place, and due to the ceuse(s) end manner steted. 29c. Licensa number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier July 1, 1999 D22751 dusau Owens, less 30. Name end eddress of person who completed ceuse of death (Itam 23a) (Type, Print) HOSPITAL CENTER RAUDALISTONN, MD NORTHWEST JUSAN OWERS MD

DHMH 16 Rev 6/95

Registrar

31. Dete filed (Month, Dey, Year) JUL 0 6 1999

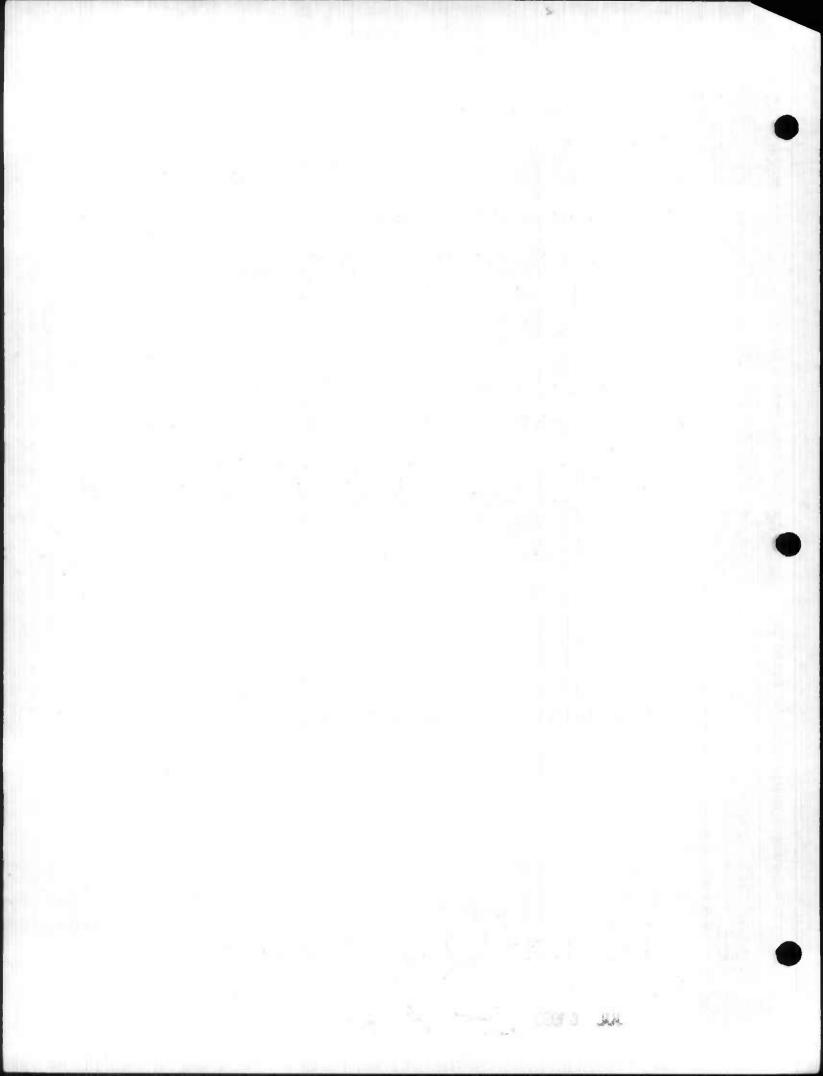
32. Registrer's Signature



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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_ P 4	11. Merital Stetus	12. Was Decedent Ever	in U,S. 13. W		dispanic Origin? (Speen, Mexicen, Puerto	ecify Yes or No-	14. Rece	- American Ir	ndien,
0 6 5 9 1		Armed Forces?  1 □ (Yes 2 □ No If Yes, Give	I J T G			Rican, etc.)	Bleck	k, White, etc.	
Dy by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Detes:	1945	☐ Yes 2 XNo	Specify:		Specify:	Whit	e
1 21215-0 ed within 72 ho ygjene. or the Medical rt, the Medical Completed	15. Decedent's	Education	16a. Decede	ent's Usual Occup	oation		16b. Kind of Bu	siness/Industr	ry
ple	(Specify only highest (Secondary (0-12)	grede completed) College (1-4or 5+)	(Give k	ind of work done O NOT use retire	during most of work d)	king			
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tal Hyger tal Hy	17. Fether's Neme (First, Middle, La	st)	OOII	BULLAII	18. Mother's Name	(First, Middle, N	ALCII	itect	ure
Maryland 21215-0020 d 2 should be filed within 72 hours of h and Mental Hygiene. 7 is marked other than "natural", or traumatic event, the Modical Exam To Be Completed by F	William	F. Heavey			Tu 1	ia Melo	aham		
Maryland 21; d 2 should be filed with th and Mental Hygiene 7 is marked other the traumatic event, the	19e. Informent's Neme/Reletionship		19b. Meiling	Address (Street	end Number or Rure			Stete Zin Con	de)
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Baltimore, permit. Peges 1 er Department of Heal Important: if Item 2 any Injury or other	4 □ Donetion 5 □ Other (Spe 21. Signeture of Funerel Service Lice		Metro C	remato	ry, Inc.	07/05	/99 Ba	ltimore	e, MD
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		Gregorchik	29	9 Frede	erick Rd	. Balti	imore,	MD 2	1228
	23e. Pert1. Enter the disease, or co shock, or heart failure. List on	implications that caused the one cause on each line.	death. Do not enter	r the mode of dyin	ng, such es cerdiec d	or respiretory erre	st,	App	proximete ervel Between
Physiclan		1 ( -							set end Deeth
/Medical Examiner	Immediate Cause (Final disease or condition	. 1101	EM1	A				2	1 NERIA
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68 /60 ficete be a physician is the burie	Ceuse (Disease or injury thet Initiated events resulting in death) Lest  Due to (or es e consequence of):								
BOX 6  Both certific  ettending i	1	d						1	
dea de	Pert II. Other significent conditions	contributing to death but not	resulting in the unc	derlying ceuse giv	ven in Pert I.	23b. Did tot	oecco uea con	tribute to the	cause of death?
I HECOTGS, P.O. BOX The law requires that the death cent te hes been signed by the ettendin page 2 should be deteched for use completed by Physician/M	1 / schtan	IIC CAN	D. c. Ma	Van	17214	1 🗆 Ye	s 2 No	3 Probably	y 4 Unknown
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The law requir The law requir page 2 should Completed						1□ Ye	s 2 <b>X</b> No		
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deat deat	3 Sulcide 6 Could not	be one Place of Injury	At home form street			28f. Location (Str	not and Numbe	or Or Purel Do	uto Number
DIVISION C tall or Attending P rs efter death. all Director: After t ed in by the funers Certification:	4 Homicide determine	building, etc. (Sp	pecify)	or, raciory, cirica		City or Town,	Stete)	or Hurar Hot	no realizar,
C 6235	29e. Certifier 1 Certifying	Physician: To the heat of	knowledge death	Monument at the 41-	me date and -l	and due to the	ueele\ ===	2005 02 21-1-1	
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o the Hospi vithin 24 hours to the Funer empletely fill	29b. Signeture end title of certifier		. /	ZGC. LIGHTS	COLUMN TO COLUMN	25	u. Dete signed	(MOHILL, Day.	1001)
DIVISION O To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th ampletely filled in by the funeral Medical Certification:	29b. Signeture end title of certifier	-	, 1	2 SC. LICENS		CU 28	7 (	- G Q	,
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DHMH 16 Rev 6/95



### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth 2, Clarence Gibson Hopkins July 1999 3:30 AM 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Future Care of the Chesapeake Arnold Arundel Anne 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) Deys 100 M 2 F Months Hours Min 212-10-7532 JAN 25, 1907 Maryland Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Maryland Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 500 Lymington Road 21146 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes; Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: White 3X Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) District Manager Meat Supply Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Clarence Stevens Hopkins Ada Gibson 19e. Informent's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet H. Bauer/Daughter 500 Lymington Road Severna Park, MD 21146 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metro Crematory, Inc. 7/2/99 Baltimore, MD 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Edward A regnoh Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD Gregorchik 21228 23e. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting In deeth) Lest Due to (or es e consequence of) Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2QNo 3 Probably 4 Unknown 24b. Were autopsy findings avelleble prior to 24e. Wes en autopsy performed? completion of cause of death? lan vascu 1 ☐ Yes 2 ☐ No 1 Yes diseas 25. Was case referred to medical 26. Piece of Deeth (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 5 Pending 1 Yes 2 No investigation 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Examiner Examiner physician and s the burial-transit Division of Vital Records, P.O. Box 68760, Physician/Medical as usa signed by t p Completed paga 2 cartificata Hospital or Attending Physician: Be 0 this funaraí Certification: Aftar aftar death. Director: Aft 24 hours a Medical nplataly within 2

**Physician** 

/Medical

Examiner

Directo

Funeral

by

**Funeral** 

Director

7 is marked other than "natural", or flams 23a or treumstic event, the Medical Examinar must be i

5 Department of important: If any injury or

**Physician** 

/Medicai

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiena. Int: If Item 27 is marked other than "natural", or Itama 23.

Baitlmore,

Hygiena.

tha Maryland

exeminer? 1 Yes 2 No 27. Mepner of Deeth Neturel 2 Accident 3 Sulcide 4 | Homicide

31. Date filed (Month, Day, Year)

(Check only one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Nende end address of person who completed cause of deeth (Item 23a) (Type, Print) ebec

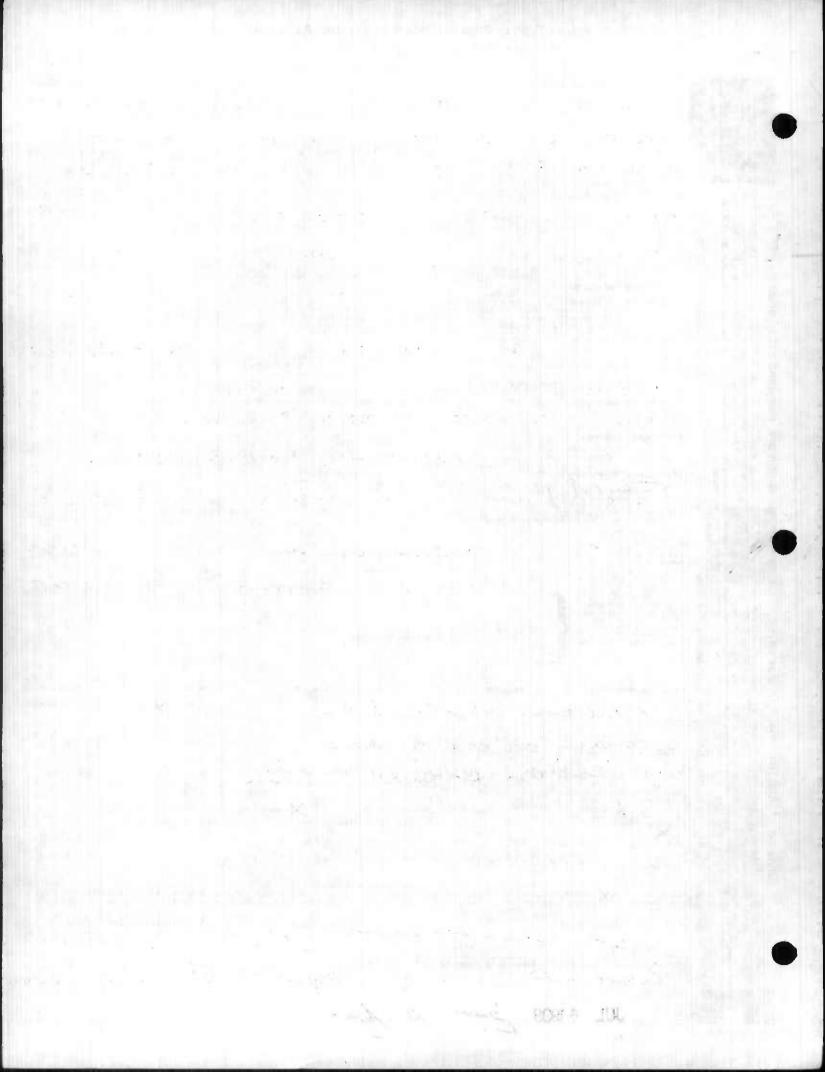
Severna Park

State Registrar

6 1999

32. Registrer's Signeture

DHMH 16 Rev 6/95



99-3815-005 CJ Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Wendy Lee State of Maryland / Department of Health and Mental Hygiene Hightower AMEND ITEMS: #23 PART 1, 27, 28A-F PER MEO G773 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Wendy Lee Hightower 03 1999 10:20 AM. July /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 4018 Annapolis Road Baltimore Highlands Baltimore Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 38 215 88 2166 Nov. 30, **Director** Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1 ☐ Yes 2 No Baltimore Highlands Directo 28a-f 10e. Street and Number 10f. Zlo Code 10g. Citizen of What Country? b 4018 Annapolis Road 21227 U.S. Barne 23e Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 'natural', or 1 Yes 2 No Specify: Specify: ğ 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Medical Technician Medical 1 year 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First Middle Last) Be permit. Pages 1 and 2 should be i Department of Health and Menial important: If them 27 is marked of any Injury or other traumatic eve Melvin Sandusky Sr. Barbara Ann Beall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Melvin Sandusky Sr. / Father 8403 Forrest Drive Pasadena, Maryland 21122 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 █ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 7/8/99 Holy Cross Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland of Funerel Selvice License 22. Name end Address of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Intervel Between Onset and Deeth **Physician** Immediete Cause (Finel disease or condition resulting in deeth) /Medical MIXED DRUG INTOXICATION Examiner Due to (or es a consequence of): The law requires that the death certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as e consequence of):

Examine edicai Physician/M signed by to þ Completed Be Certification: To

980

the

165

within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

29e. Certifier

(Check only

29b. Signature end title of certifier

death.

vithin 24 hour

Box 68760.

Records, P.O.

Division of Vital or Attanding Physician:

that initiated events resulting in death) Lest	Due to (or as a consequence of):					
Pert II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use co	ntribute to the causs of death			
		24a. Wes an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?			
25. Was case referred to medical	26. Place of Death (Check only one)					
examiner? 1 🏹 Yes 2 🗌 No	Hospital:	Home 5X Residence 6 □Other (Specify)				
27. Menner of Death  1 Neturel 5 Pending investigeti	28a. Dete of Injury (Month, Dey Year)  Pound: 7-3-99  28b. Time of A logury at Work?  Found: 7:00  1 □ Yes 2 ☑ No	28d. Describe how injury occurred SUBJECT INGESTED DRUGS				
3 ☐ Suicide 6 ☑ Could not determined		281. Location (Street and Number or Rival Route Number, City or Town, State A 0 18 ANNAPOL 15 RD. BALTIMORE, MD				

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and plece, and due to the cause(s) and manner stated.

State Registrar

edicai

Strphen S.
31. Dete filed (Month, Day, Year) 32. Registrer's Signature 0 6 1999

Radentz

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)

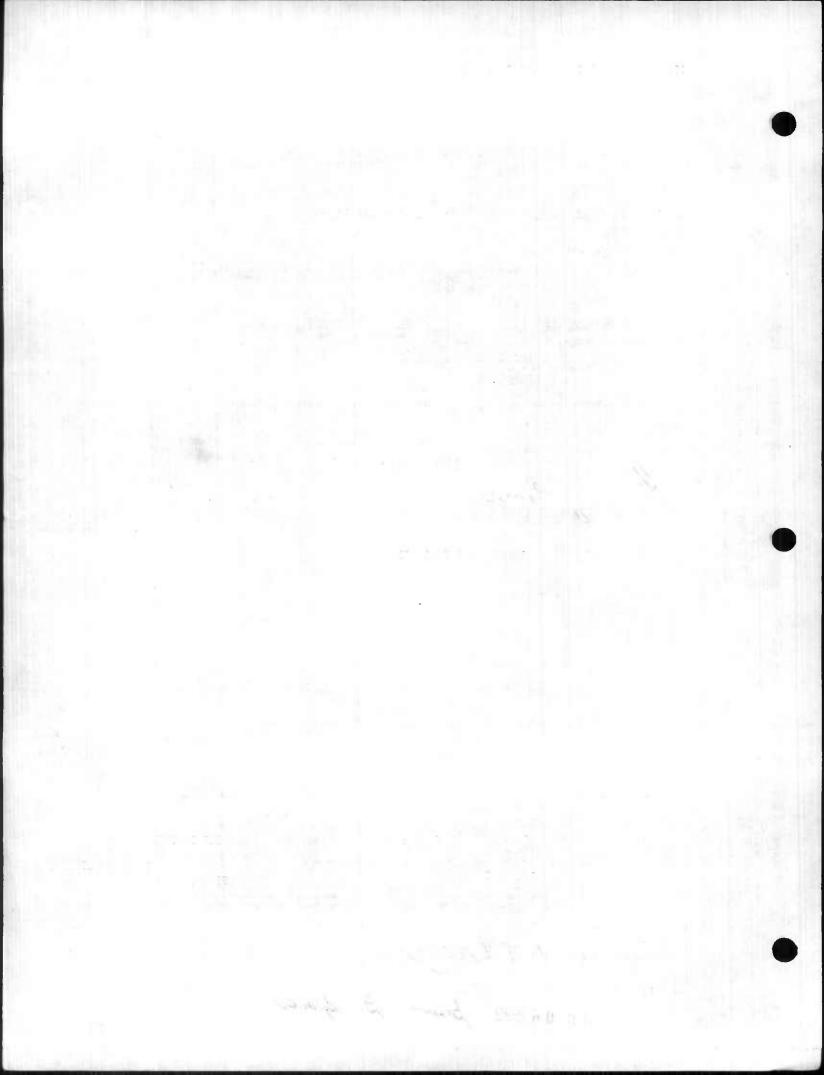
111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 4, 1999

MP



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

IVES,

JAMES	S
<b>IVES</b>	JR.

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death

**Physician** /Medical Examiner

Director

by

Completed

Be

4a Facility Name (If not Institution, give street and number)

10b. County

911 MOUNTAIN ROAD

JR. JUNE 4b. City, Town, or Location of Death

3. Time of Death 2:50P.M.

**Funeral** Director 5. Social Security Number 212 36 9361 Usual Rasidence of Decedant

7. Age (In yrs. last birthday) XXM 2DF 60 Yrs.

**JOPPA** If Under 1 Year | If Under 24 Hrs. Months Days Hours

8. Data of Birth (Month, Day, Year) Aug. 8, 1938

30,1999

4c. County of Death

HARFORD

 Birthplace (Stata or Foreign Country) Maryland

28a-f

b

Berns 23a

"netural", or

I flad within 7 I Hygiene. Other than "n

permit. Pages 1 and 2 should be file.
Department of Health and Mantal Hyg.
Important: If Item 27 is marked other
any injury or other traumers of other

Physician /Medical

Examiner

physician and the burial-transit

signed by the a

Box 68760.

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Records.

of Vital

Division

that the death certificate be

The

Attending Physician:

6

this

After

death.

Hospital
 24 hours a
 Funeral D

To the Hosp within 24 ho To the Fune completely fi

after deat Director:

72 hours after

Baltimore, Maryland 21215-0020

10a Stata Maryland 10e. Street and Number

**JAMES** 

Harford

10c. City, Town or Location Joppa

10f. Zip Code 10g. Citizen of What Country?

10d. Inside City Limits 1 Yas XX No

911 Mountain Rd.

11. Marital Status 1 Nevar Married 2 Married 3 XWidowed 4 ☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No

21085 Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1 Yes 200 Specify:

14. Race - American Indian. Black, Whita, etc. White Specify:

15. Decedent's Education (Specify only highast grada completed) Elementary/Secondary (0-12)

College (1-4or 5+) 5+

Sr.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Construction

Lee

United States

17. Father's Nama (First, Middla, Last)

Wilcox James

Ives,

olunar

Laborer

18. Mother's Nama (First, Middla, Maidan Sumama)

Margaret

19a. Informent's Name/Ralationship (Type, Print)

4 ☐ Donation 5 ☐ Othar (Specify)

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 200 Belmont Forest Ct., #101, Timonium, MD 21093

James W. Ives, Sr./ Father 20a. Mathod of Disposition

1 Burial 2 Cramation 3 Removal from Stata

20b. Place of Disposition (Name of cemetery, crematory or other place) Green Mount Crematory

7/3/99

20c. Location - City or Town, Stata Baltimore, MD

Examiner

Physician/Medical

by

Completed

Be

To

Certification:

Immediata Causa (Final

8717 Green Pastures Dr., Baltimore, MD 23a. Part1. Entar the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona cause on each line.

22. Nema and Address of Facility CAFA Stephen D. Lohrmann P.A.

Approximate Interval Between Onset and Death

21286

disease or condition rasulting in death)

CONTACT SHOTGON WOUND OF CHEST Due to (or as a consequence of)

SUDDEN

Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events that initiated events rasulting in death) Last

Dua to (or as a consequence of):

Due to (or as a consequence of)

23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

24a. Was an autopsy performed?

24b. Were autopsy findings available prior to

1 X Yas 2 No

completion of cause of death? 1 Yas 2□ No

25. Was casa refarred to medical axaminer? MYas 2□ No

5 Pending investigation

6 ☐ Could not be

1 Inpatient Nonth 30

2 ER/Outpatient 3 DOA 28b. Time of Injury APPROX NOON

28c. Injury at Work? 1 Yes 2 No

Other 4 Nursing Home 5 ₹ Residence 6 Other (Specify) 28d. Dascribe how injury occurred

> SHOT SELF 28f. Location (Street and Number or Rural Routa Number, City of Town, Stata)
> 911 MOUNTHINKO, TOPPA, 1 YOPPA, MD

29e. Certifier (Check only one) 1 Certifying Physician 1 tha best of my knowledge, death occurred at the time, date end place, and dua to the cause(s) and manner as stated.
2 Medical Example: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

26. Place of Death (Check only ona)

29d. Data signed (Month, Day, Year)

29b. Signature and

27. Mannar of Death

1 Natural

2 Accidant

3 Suicida
4 Homicida

29c. License number

Place of Injury - At home, farm, street, factory, office building, etc. (Southy)

OME

O.C.M.E.

JULY 1,1999

30. Name and

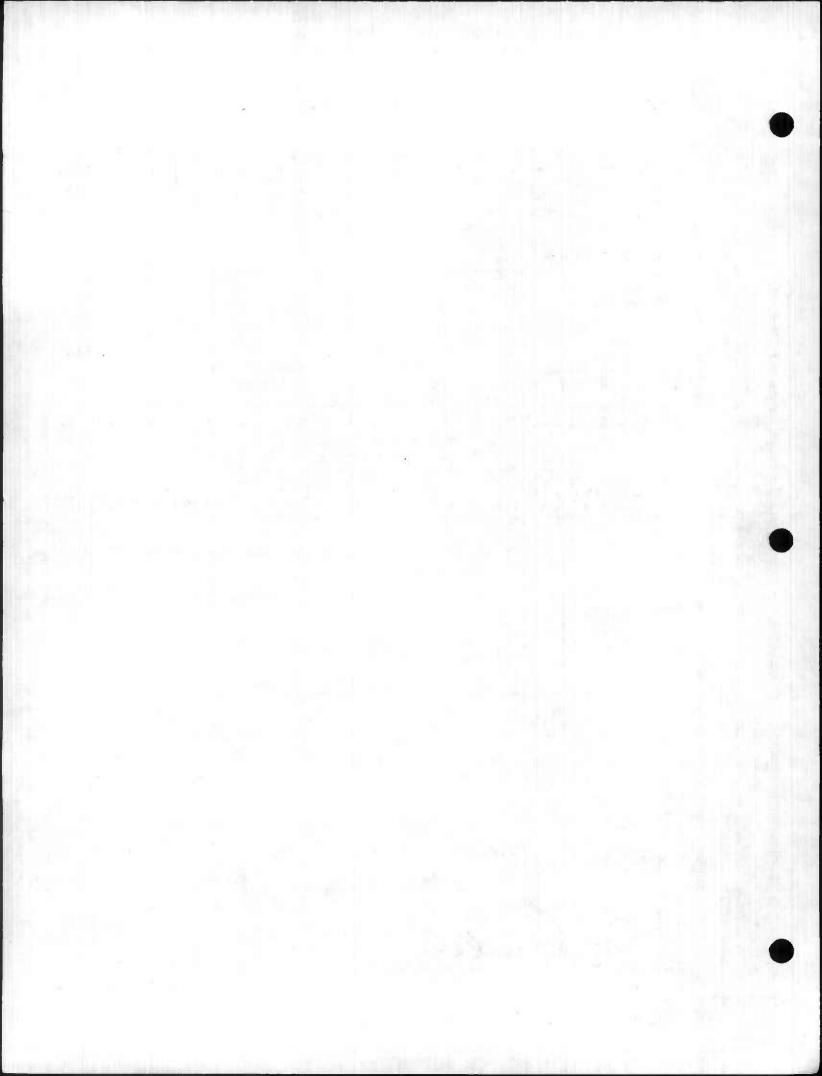
complated cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Data filed (Month, Day, Year) JUL 0 6 1999

32. Registrar's Signature

DHMH 16 Rev 6/95



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Dev Year Month OTIS NATHANIEL JONES 9:00am 4, JULY 1999 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death 201 N. WASHINGTON ST APT 506 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Deta of Birth (Month, Dey, Year) Birthplace (State or Foraign Country) Months Hours 1₩ 2□ F 82 264-09-1342 10 - 21 - 16CORDELE, GA Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits TY Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 201 N. WASHINGTON ST 506 21231 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Bleck, White, etc. 1 Never Married 2 Merried 1 Xves 2 No If Yas, Give 1 Yes 2 No BLACK Specify: 3€ Widowed 4 Divorced Year or Dates: Decedent's Usuel Occupation (Give kind of work done during most of working iffe. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) MERCY HOSPITAL DOMESTIC 10 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) OTIS JONES OPHELIA EXION 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 501 HIGHLAND AVE, IVORY JONES, SON BALTO. MD 21205 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 St Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 7-9-99 OWINGS MILLS, MD GARRISON FOREST 21. Signature of Funerel Service Licensee HOWELL FUNERAL HOME 4600 LIBERTY HGHTS AVE, BALTO. MD 21207 tart). Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or haert failura. List only one cause on sech line. Approximete Intervel Batweer Onset end Death Immediata Causa (Final diseasa or condition resulting in daeth) Sequentially list conditions, if eny, leeding to immadiate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last Due to (or es a consequence of Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera eutopsy findings eveilable prior to complation of causa of death? 24a. Wes en eutopsy performed? 2) No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examinar? 26. Place of Death (Check only ona) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Manner of Deeth 28e. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed P.O. of Vitai Records. Hospital or Attending Physician: Division

**Physician** 

/Medical

Examiner

Director

þ

Completed

Be

**Funeral** 

Director

filed within 72 hours after death with the Manyland

21215-0020

Baitimore, Maryland

Pages 1 and 2 should be filed within remeas.

ment of Health and Mental Hygiene.

nant: if ham 27 is marked other than "natural", or items 23s or 28s-f show

nant: if ham 27 is marked other than "natural", or items 23s or 28s-f show

permit. Page Department of Important: If any injury or

**Physician** 

/Medical Examiner

Examine

Physician/Medical

P

Completed

4 Homicida

29b. Signeture and title of certifie

3

29e. Certifier

after death.

Director: After this certification of in by the funeral director, Medical Certification: To Be within 24 hours of To the Funeral (

To the

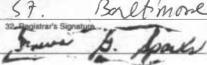
page

State Registrar

**DHMH 16 Rev 6/95** 

31. Dete filed (Month, Dey, Kear)

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person who complated causa of death (Item 23a) (Type, Print)

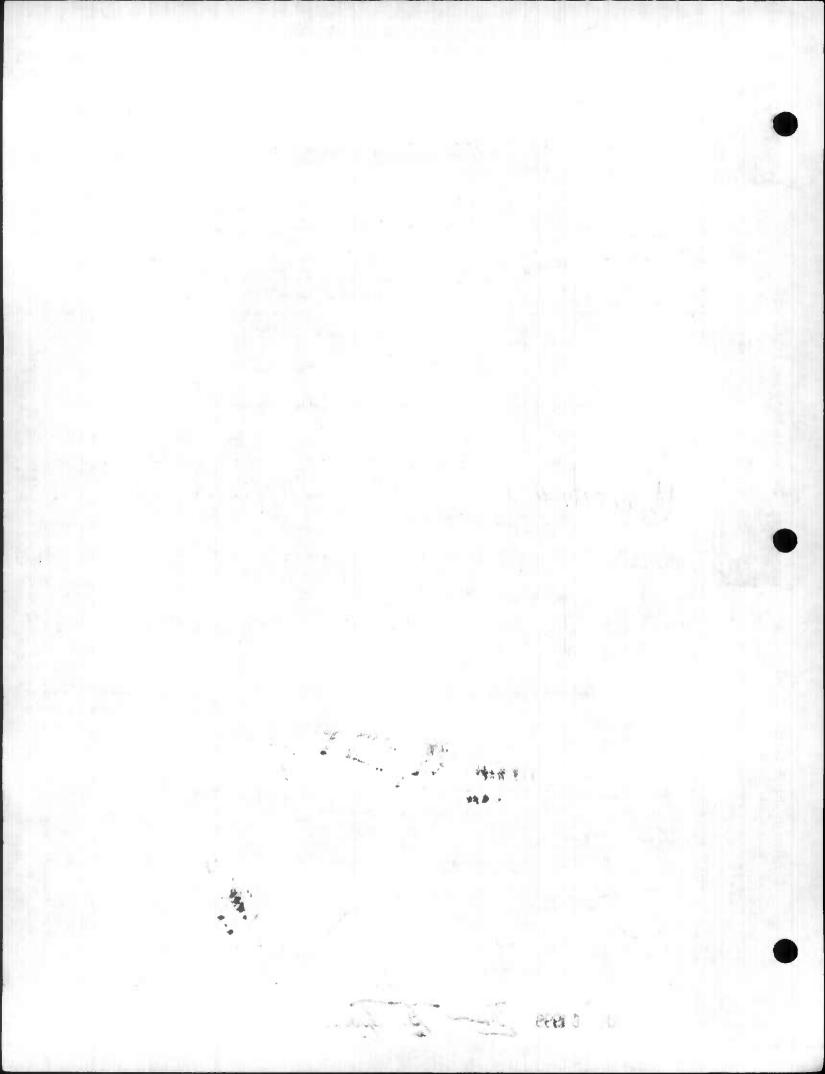
**ORIGINAL** 

1 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, date end place, and dua to tha causa(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end mannar stated.

29c. License number

MD 21

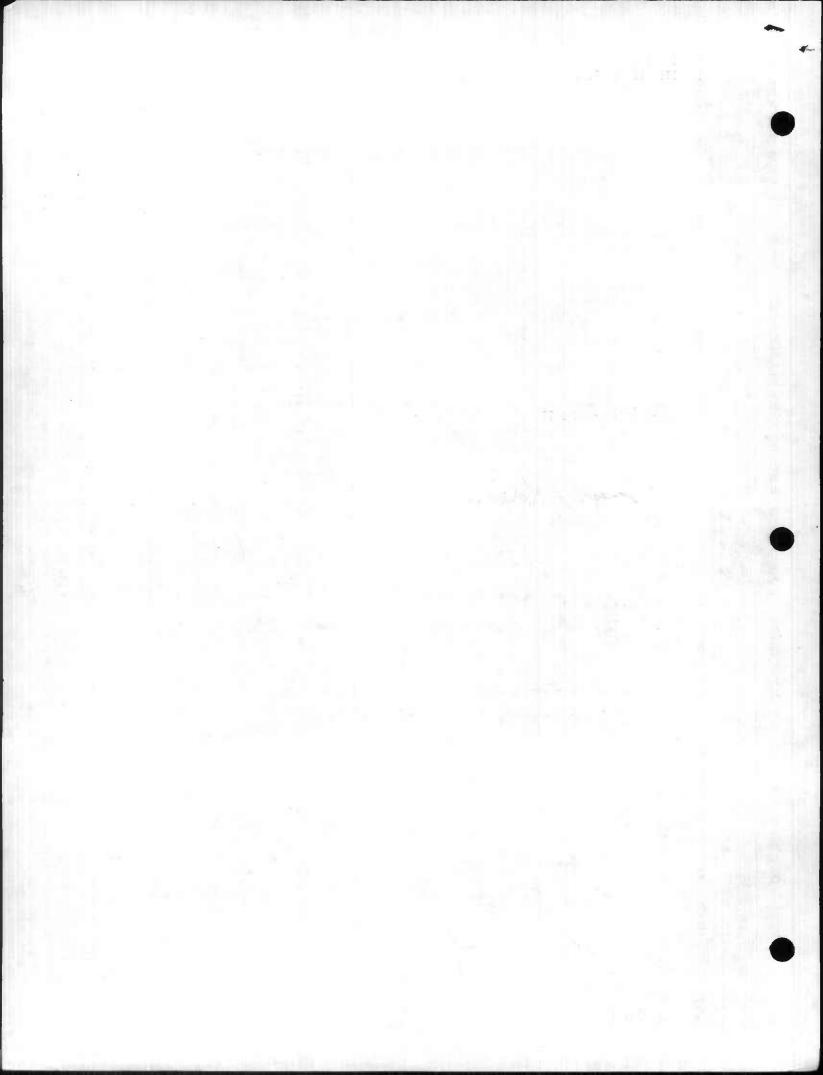
29d. Dete signed (Month, Day, Year)



DHMH 16 Rev 6/95

Registrar

JUL 0 6 1999



#### 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** Marie Theresa Knoerlein 5 July /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Heritage - Meridian Dundalk If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. last birthdey) **Funeral** 1 M 2 F Months Deys 89 219-20-5765 Director Sept 16 1909 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If item 27 is marked other than "netural" — any fullury or other traumatic averages. KNOERURIN 10e. Stele 10c. City. Town or Location 10b. County MD Baltimore Dundalk Director 10e. Street and Number 10f. Zip Code t0g. Citizen of What Country? 602 Teejay Lane 21222 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Menitel Stelus 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No Specify: ٥ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Housewife Own Home 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) John Trompetor Elizabeth Antmann 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) William Knoerlein 7318 Kirtley Rd Baltimore, MD 21224 /son 20b. Place of Disposition (Name of cemetery, cremetory or other place) Cem. 20e. Method of Disposition 20c. Location - City or Town, Stata Dete 8 July 1 Burlet 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Sacred Heart of Jesus 1999 Baltimore, MD 21. Signeture of Funerel Service Licenses 22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222 23e. Pert1. Enter the discrete, or complications that caused the district. Do not enter the mode of dying, such as cardiac or respiratory errest, abock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death YNDROME OF INAPPROPRITE ANTIDIURETIC HORMONE Immediate Cause (Final diseasa or condition resulting in death) CHRONIC RENA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events that initiated events resulting in death) Last

Due to (or es e consequença of): ESMELLIT DIABET RONARY DISEASE

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

EARS

3. Time of Death

1:10 AM

Birthplace (State or Foreign Country)

10d. Inalde City Limits

1 ☐ Yes 2 X No

1999

Baltimore

USA

MD

14. Reca - American Indien

White

Black, Whita, etc.

Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I.

THSIVE APTERIOSCLEROTIC CARDIOVASCULAR UROSEPSLS. OLD CEREBROVASCULAR THROMBOSIS 23b. Did tobacco use contributa to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were eutopsy findings evailable prior to completion of cause of death?

26. Place of Deeth (Check only one)

1□ Yes 2□ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Dete of Injury (Month, Dey Year) 5 Panding investigation

28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 🗆 No

28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

29a. Certifier (Check only one)

2 Accident

3 ☐ Sulcide

4 T Homicide

1x Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signatu

6 Could not be determined

29c. License number

29d. Dele signed (Month, Dey, Year)

And Sonse along the (4000530) And John CHIE HIGHWAY,

State Registrar

32. Registrer's Signature

DHMH 16 Rav 6/95

**Physician** 

/Medical Examiner

attending physician and for use as the burial-transit

Box 68760

P.O.

Division of Vital Records,

Examiner

Physician/Medical

by

Be

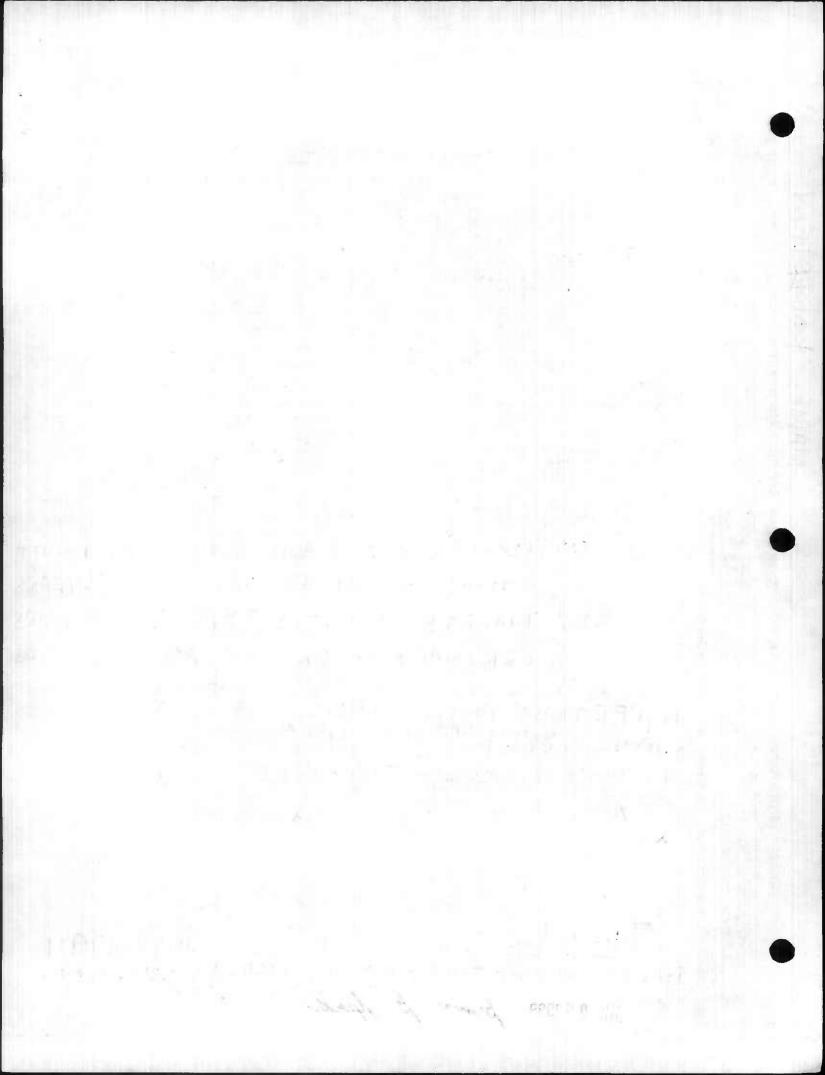
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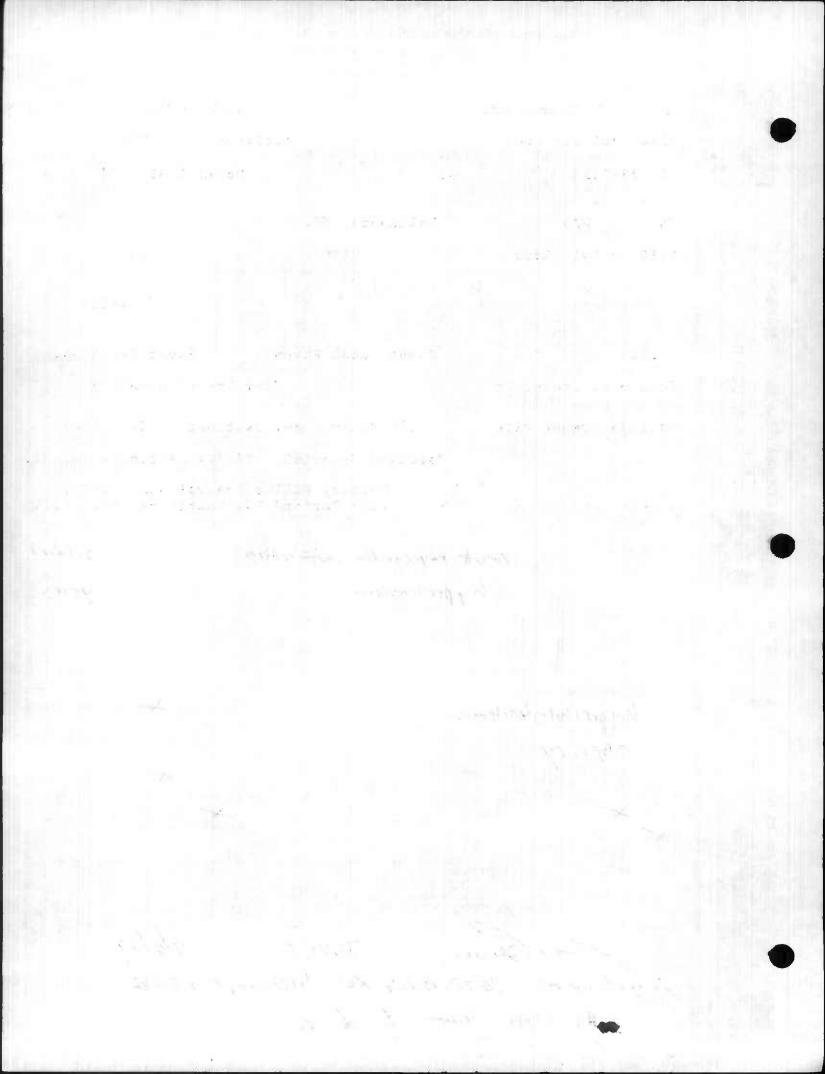
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## Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 0 1 1 6 5

		Decedent's Nar	me (First, Middla,	Last)						2. Date of Dea		Vaar	3. Time of Death
sician. edical		Eugene	P. Kr	ess, J	fr.					July	5 1999	Year	9:30
miner	4.0		(If not institution,					4b. City	y, Town, or L	ocation of Death			
		4510	Hellwig	g Road				В	Baltin	nore	N	/ A	
al or		Social Security 2 18 - 56	-1530	6. Sex 1 ØM 2□	F	yrs. last birthday) + 7 Yrs.	If Under 1 Ye Months Day		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day Oct 23	7, Year) 1951	9. Birth Cou M d	nplace (Stata or Foreign intry) [
	-	sual Residance ( a. State	10b. County		100	c. City, Town or Lo	ocation						10d. Inside City Limits
tor	1	Md	N/A			Balti	more,	Md.					1 Nes 2 No
rec	10	e. Street end No	umber				10f. Zip Code				10g. Citizen of	Whet Cou	untry?
2	1	4510 H	ellwig	Road			212	06			U	SA	
To Be Completed by Funeral Director	11		rried 2⊠ Marrie	Armed	Decedent Ever d Forces? es 2 No , Give or Detes:		Was Decedent of the Yes, specify C			pecify Yes or No- Rican, etc.)		ce - Americk, White	
	-	3 🗆 ***********************************	15. Decedent's		or Detes.	16a Dece	dent's Usual Occ	cunation					
	-	(Spe	ecify only highast	grada complate	ed) ge (1-4or 5+)	16a. Decedent's Usual Occupation (Giva kind of work dona during most of world life. DO NOT usa ratired)				iusiness/Industry			
		12th N/A Sheet Metal Foreman Sheet  17. Father's Name (First, Middla, Last)  18. Mother's Name (First, Middla, Maidan Surria.								1 Co.			
	17							18. M					
		Lugene	P. Kre	ess, S	r.				Mary	y Kress	( How	ell	)
		9a. tnformant's N	Name/Relationshi	ip (Type, Print)		19b. Maili	ing Addrass (Stre	et and N	umber or Rui	ral Routa Numbe	er, City or Town	Stata, Zi	ip Coda)
			a Kress	s/ wif		4510	Hellw	ig R	Rd. Ba		e, Md	. 2	1206
	20	a. Mathod of Dis	sposition Cremation :	3 □Removal fr		Ob. Place of Dispo cematary, cra	osition (Nama of matory or othar p	olace)		Dete	20c. Location	- City or T	Fown, State
			5 Other (Spe		om olato	Morela	nd Men	oria	11	7/9/99	Balti	more	Co. Md.
	Im di: re	3a. Part1. Enter shock, or no nmediata Causa sease or conditi sulting in death)	(Final			death. Do not en	ter the mode of o	dying, suc	ch as cardiac	or respiratory ar	imore	, Md	Approximate Intarval Between Onset and Death
100100	Im dii re	nmediata Causa sease or conditi	onditions, immediate larlying or injury ts	a	Due hy	death. Do not end  Myccq  to (or as a consect  to (or as a consect  to (or as a consect	quence of):	dying, suc	ch as cardiac	or respiratory ar	imore rest,	, Md	Approximate Interval Between
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) JUZ> 1999 09280m 1LBERT 1-FMOTNE **Physician** /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner HARBOR HOSPITAL CENTER BALTIMORE 5. Social Security Number 218-30-6888 If Under 1 Year If Under 24 Hrs. Sex 1 M 2□ F 7. Age (In yrs. last birthday) Birthpiace (State or Foreign
 Country) Deys 6 Yrs. France Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours aftar death with the Marylend nent of Heatth and Mental Hygiene. Int if them 27 is marked other than "natural", or thems 23s or 28s-1 show 10a State 10b. County City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner must be not (set at 1 Yes 2 No Anne Hrun Director 10f. Zip Code 10g. Citizen of What Country? 21090 ewood Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 0 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) American Indian 11. Marital Status 1 Never Married 2 Married 1□ Yes 2 No à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coilege (1-4or 5+) Elementary/Secondary (0-12) Heavy Equipment 17. Father's Name (First, Middle, Last) Name (First, Middle, Maiden Surname) Be Braban phonse ctorine emoine inthicum Mi) item 2 20b. Place of Disposition (Name) cametery, crematory or other 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Sul m02122 the death. Do not enter the mode of dying, such as cer 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical MYOCARDIA **Examiner** Completed by Physician/Medical Examiner physician and the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) esn signed by the a d be detached f Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4) Unknown COPD, MI, CVA-24b. Were eutopsy findings evailable prior to 24a. Was en autopsy performed? completion of ceuse of death? i certificate has b 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 30 DOA 1 Inpatient 2 ER/Outpatient After this funerel 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28h Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural after death. 1 Tes 2 No 2 ☐ Accident 6 Could not be determined n 24 hours after dea Ne Funerei Director Dietaly filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. Medical 29a. Certifier completaly (Check only one) To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signaturelland title

State Registrar

monthson Jahnestamen ... Life Commenced For House England of Total and Control of "MORNING PRIVACION" Mark Contract to the State of t The Company sections and the second

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) JULY 1999 8-14 pm 04 Mary L. Ledley AC. County of Death 4a Facility Name (If not institution, give street and number) NORTH PRUMPEL HOSPITAL 4b. City, Town, or Location of Death GLEN BURNIE If Undar 1 Year | If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthpiace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Hours 1 M 2K) F 213 10 1912 Yrs May 17, 1916 Maryland Usual Residence of Deceden 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1914 Cedar Road 21122 U.S. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ᢓ No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian. 11. Maritai Status Black, White, etc. 1 ☐ Never Marriad 2 ☐ Married 1 Ves 2 No Specify White 30 Widowed 4 □ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Flementery/Secondary (0-12) College (1-4or 5+) Clerk Retail Store Not Available 18. Mother's Name (First, Middle, Meiden Surname) 17 Father's Name (First Middle Last) Emma Wroten James Neill 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Margaret Bardroff / Daughter 1914 Cedar Road Pasadena, Maryland 21122 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1⊠ Buriai 2 □ Cramation 3 □ Ramoval from State Glen Haven Memorial Park 7/9/99 Glen Burnie, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signatury Funeral Service Licenses 22. Name and Addrass of Facility Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225 complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, only one cause on each line. Approximete interval Between Onset and Death immediate Cause (Final . CHRONIC OBSTRUCTIVE PULMONARY disaase or condition resulting in death) DISEASE CONGESTIVE HEART FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Lsst Due to (or as a consequence of): Due to (or as a consequence of) 23b. Did tobacco use contributs to the cause of death? Part II. Other stanfficant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 3 Probably 4 □ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to 24e. Wes an eutopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 No 25. Was cese referred to medical axaminar? 26. Place of Death (Check only one) Othar: 4 Nursing Home 5 Raaidance 6 Other (Specify) 1 ☐ Yes 2 No 1 Appatiant 2 ER/Outpalien 3 DOA

**Physician** /Medical Examine

Examiner

Physician/Medical

ð

Completed

10

Certification:

Medical

27. Manner of Death

1 Natural 2 Accident

3 Sulcida

29a. Certifier

4 Homicide

(Check only one)

5 ☐ Pending

investigation 6 ☐ Could not be determined

**Physician** 

/Medical

Examiner

Directo

Funeral

p

Completed

**Funeral** 

**Director** 

7 is marked other than "natural", or itema 23s or 28s-f shot trsumstic event, the Modical Examines must be notified as

Hygiene.

Health and 2 should be fill Health and Mental H Iem 27 Is marked oth

permit. Pages 1 and 2 Department of Health a Important: If item 27 is

any Injury or o

the Maryland

altimore, Maryland 21215-0020

EDLEY,

physician and the burial-tran Se use i Po 8 page 2 s has certificate

director. this funeral

Attending Physician: 2 5

Division of Vital Records, s after death.

To the Hospital 24 hours within 2

Registrar

31. Date filed (Month, Dey, Year) JUL 0 6 1999

29b. Signature and title of certifier

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) SUDHTR KUMBR AGGARMAL NORTH ARUNDEL HOSPITAL, 301 HOSPITAL DRIVE, GLENBURNIE, MD 21061

28a. Date of Injury (Month, Day Year)

m,0)

28c. fnjury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) end manner es stated.

2 Madical Examiner: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

1 Yes 2 No

D51664

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

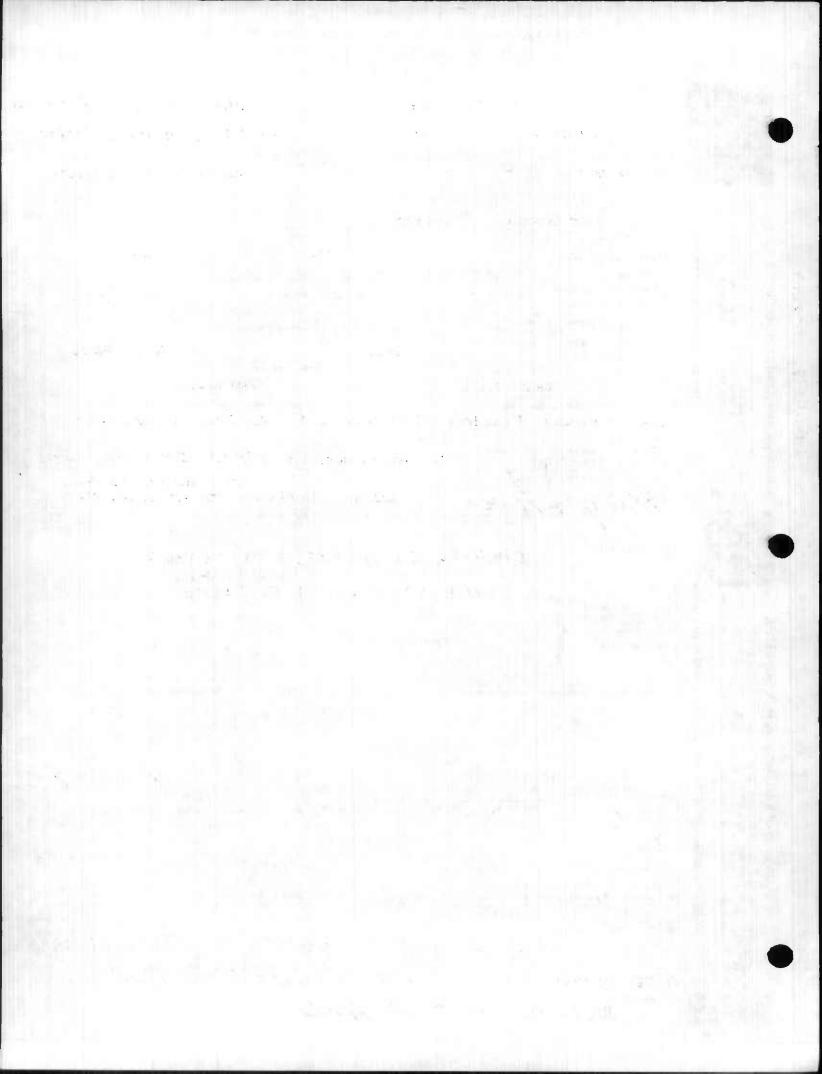
JULY

29d. Date signed (Month, Day, Year)

32. Redistrar's Signeture doorly

28b. Time of

28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify)



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 2, 6:15 A.M. 1999 ALBERT G. MCCULLOUGH JULY /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street end number) 4c. County of Death Examine MANOR CARE RUXTON TOWSON BALTIMORE If Under 1 Ye Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In vrs. lest birthdey) 8. Date of Birth (Month, Dey, Year) 6. Sex **Funeral** Min Days 1 M 2 □ F Months Hours Director 4/9/11 MARYLAND 577-10-5629 88 the Maryland 10a. State 10c. City. Town or Location 10d, Inside City Limits 10b. County "natural", or items 23a or 28a-f ahow solical Examiner must be notified at 1 ☐ Yes 2√ No Director BALTIMORE TOWSON MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with Funeral 21239 6917 LACHLAN CIRCLE USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental thygiene.
Int: If Item 27 is marked other than "natural", or the ury or other traumatic event, it a Medical Examina. Yes 2 No f Yes, Give 1 Never Merried 2 Married altimore. Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WHITE Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) SALESMAN BRICK COMPANY 10TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be ALEX MCCULLOUGH CECELIA KROLL 2 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, cremetory or other piece) CARMEL MILLER NIECE BALTIMORE, MD 21212 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Department Inportant: If any Injury or 7/6/99 ELKRIDGE, MD MEADOWRIDGE MEM. PARK 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. Enter the disease, or complications that caused the death. Do not sine rine mode of bying such as cardiac or espiratory areson, MD, or heart failure. List only one cause on each line. 21286 Interval Between Onset end Death **Physician** /Medicai Immediate Ceuse (Finel diseese or condition resulting in death) hemi Examiner Due to (or as a consequence of) Examiner requires that the death certificate be executed physician and s the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical Due to (or as a consequence of) nding p 10 signed by the aid Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings evailable prior to completion of ceuse 24a. Was an autopsy Completed performed' s certificate has t of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director Be 25. Was cese referred to medical 26. Place of Deeth (Check only one) examiner? Other: Nursing Home 5 Residence 8 Other (Specify) To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred Naturel 2 Accident 5 Pending investigation Injury 1 Yes 2 No 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examples: On the basis of example investigation, in my opinion, death occurred et the time, data and place, and due to the cause(s) and manner stated. To the Hosp within 24 hou To the Funer completely fil 29a. Certifier edicai 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifi 29c. License number 30. Name and addres of person who completed cause of death (Item 23a) (Type, Print) 17 FONTANA LANE BALTIMORE, MD RAHNAMA 32. Registrar's Signature 31. Dete filed (Month, Day, Yeer)

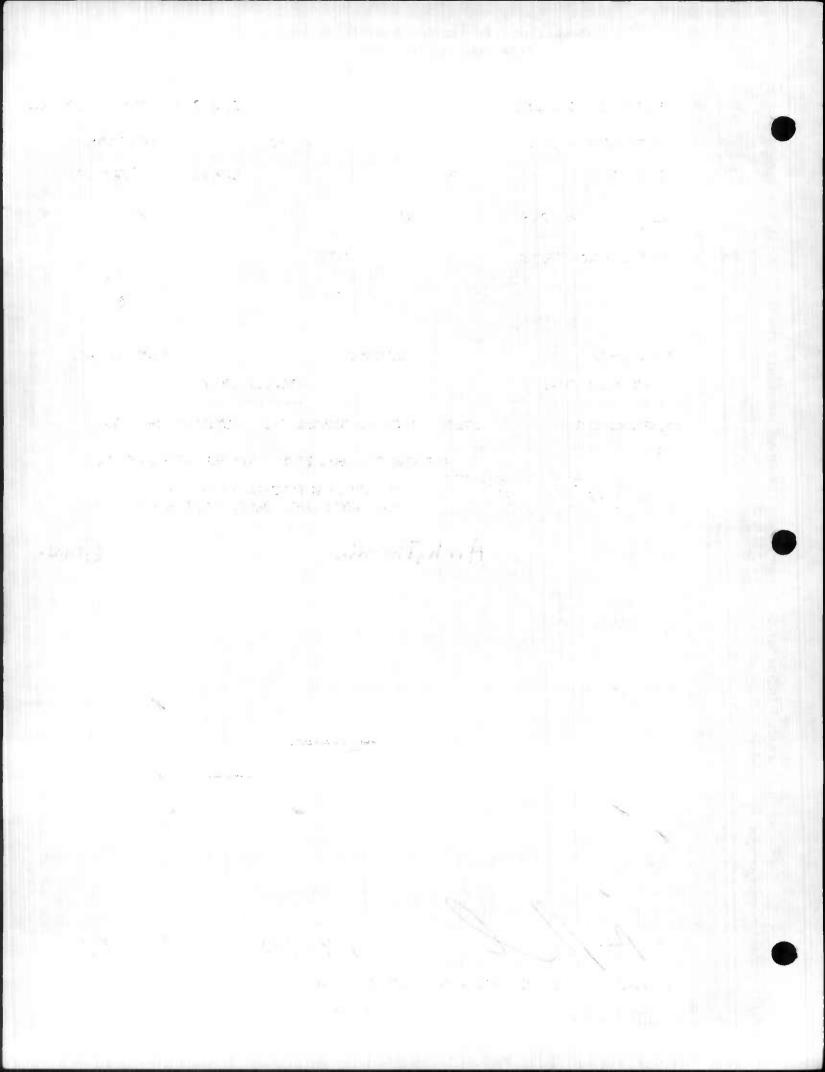
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**DHMH 16 Rev 6/95** 

State

Registrar



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		MS: #23 PART I, 27, 28A-	State of Marylar F PER MEO G774 8	nd / Department /	artmer	t of H	lealth ar Death	nd Mental Hy	/giene 9	9 2	1169	
		1. Decedent's Name (First, Middle, Last	)					2. Date of D Month		Year	3. Tima of Death	
Physici /Medi		Raymond Mat		er				JULY	02 199	9	1906	
Examir	er	4a Facility Name (If not institution, give					ESSEX	n, or Location of Dea		y of Death		
Funeral		FRANKLIN SQUARE  5. Social Security Number 6. Se		last birthday)	If Unde	r 1 Year	If Under 24	Hrs. 8. Date of B			ce (State or Foreign	
Funeral Director			THE PERSONAL PROPERTY.	5 Yrs.	Months	Days	Hours	Min. 8. Date of B (Month, D	ay, Year) 5 1994	Country	7	
Du .		Usual Residence of Decedent  10s. State 10b. County	100 0	ly, Town or Lo	antina						Line ide Circ I in in	
fanyla a sho	5	MD Baltim		oseda						100	Inside City Limits  1 ☐ Yes 2 ☑ No	
The N	Tect.	10e. Street and Number			10f. Zip	Code			10g. Citizen of What Country?			
N with	0	512 Patapsco A	ve			123	7		USA			
ter death with the Manylar flerns 23s or 28s-f show ther mass be notified st	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican,				n? (Specify Yes or N	0- 14. Ra	ca - American		
5-UUZU 72 hours after death with the Manyland natural', or items 23s or 28s-f show siss Exercise must be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:				Specify:	dono mozn, oto.,	Speci			
Z1Z15-00Z0 d within 72 hours af glene. or than "natural", or the management of the m	Pe	15. Decedent's Edu	cation	16a. Dece	dent's Usu	al Occupi	ation		16b. Kind of E	Business/Indus		
within 7. within 7. within 7. within 7. within 1. within	Completed	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or 5+)	(Give	kind of wo DO NOT u	rk done d se retired	ation during most o f)	of working				
Hygien Hygien H, II e	Соп	0		Nev	er w	ork			None			
E 2392	Be	17. Father's Name (First, Middle, Last) Robert Miller						s Name (First, Middle my Ferro		me)		
aryian should be nd Mental marked o	10	19a. Informant's Name/Relationship (T)	ma Drinth	10h Maiti		(Chana)		or Rural Route Num		State Tin C	adal	
and 2 shoeith and n 27 ie m			mother				co Av		timore			
s 1 and 1 Heel		20a. Method of Disposition	20b. I	Place of Dispo	sition (Na	me of		Date	T	- City or Town		
Balfilmore, bemit. Pages 1 ar Department of Hee montant: If Nem; any Injury or other		1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	ak La				July 6	Baltin	more.	MD	
Demit. Page Department of Important: If any Injury or		21. Signature of Funeral Service Licens						neral Ho				
0 88558		anthous C	Con OVe	/				Point			- 12	
Physician /Medical Examiner	er	23a. Part f. Enter the disease, or complished, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	SUDDEN DEATH AF		O JAVO						iterval Between Inset and Death	
icate be executed physician and s the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	bDue to (c	or as a consec	quence of):							
- 00	Cal	Cause (Disease or injury that initiated events resulting in death) Last	Due to (c	or as a conseq	juence of):							
BOX eath cert attendin	clan	Dark II. Other startiff and a scattle					- 1. D	not DI				
d by the	Physician/Med	Part II. Other algnificant conditions cor	ntributing to death but not res	umng in the u	noenying o	ause grv	en in Part I.		Yaa 22(No		he cause of death? bly 4 Unknown	
VICAL THE LAW requires that the death certificate hes been signed by the atterior, page 2 should be deteched for	Completed by								s an autopsy formed?	avail	autopsy findings able prior to pletion of cause ath?	
The is	mo							11	Kyes 2□No	100	Yes 2□ No	
ysician: The law s certificata hes b director, page 2 s	Bec	25. Was case referred to medical axaminer?					26. Place o	of Death (Check only	one)			
Physician: This certificate director,	2	1 No 2 No		ER/Outpatier			4LJ NUIS	ing Home 5 Res			AI DEMOVAL	
Attending P or death.	atlon:	27. Menner of Death 1 □ Naturel 5 □ Pending 2 ☒ Accident investigation	28a. Date of Injury (Month, Day Year) 7-2-99	Fourthey 6:25	P A	28c. Injun Worl	yat k? Yes 2∐No	FOOD BOL	US FROM S	UBJECT'S	AL REMOVAL UPPER	
- X	Certification:	3 Suicide 6 Could not be determined	1 De Disse of Injury At home from street feeten effice. 29f Location (Street and Alum)					PATAPSI MARYLA	Route Number, CO AVE . ND			
To the Hospital of within 24 hours a To the Funeral D completaly filled I	edical		sician: To the best of my kno ner: On the basis of examina and manner stated.									
To the Within To the comple	×	29b. Signature and title of certifier	1				e number		29d. Date sign			
		Stysy 1	r Mac	14	90	O.C.1	M.E		JULY (	)3,1999		
		30. Name and address of person who co	ompleted cause of death (Item	n 25a) (Type,		Peni	n Stre	et, Balti	more, Ma	aryland	1 21201	
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signi	ature						_		
Registr	_	JUL 06	1999 Deper	a K	9. 1	bou	61					

DHMH 16 Rev 6/95

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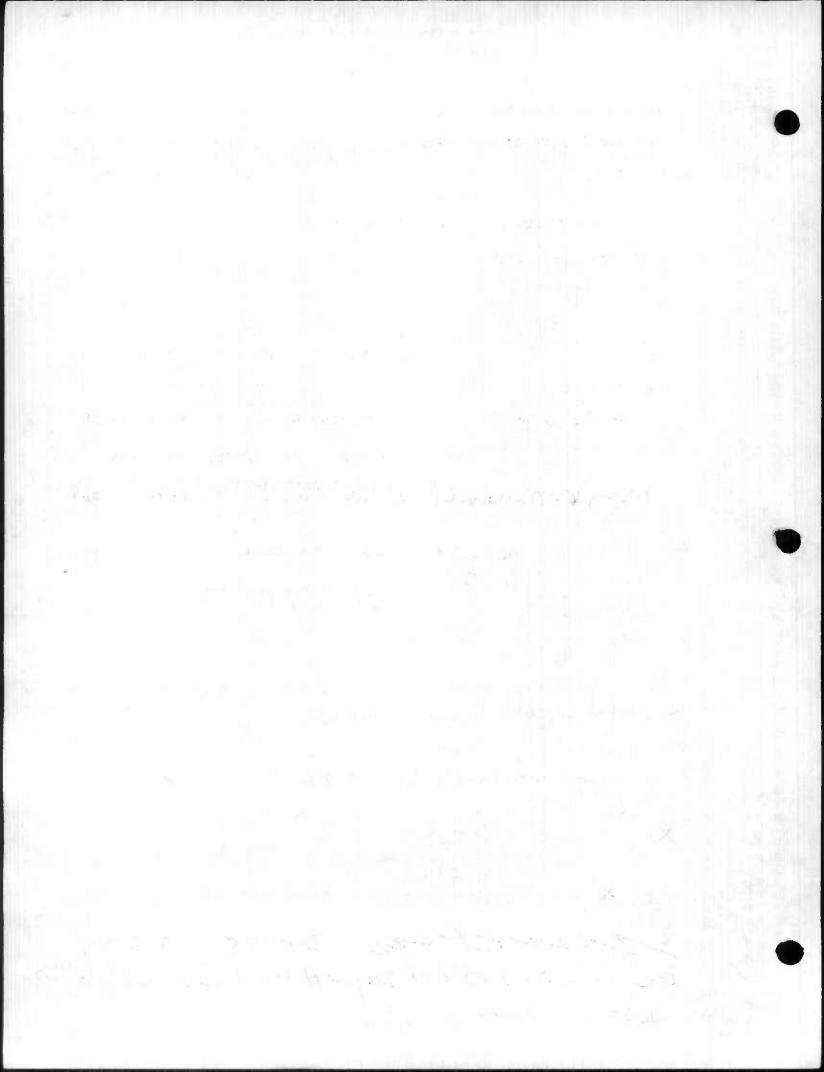
**ORIGINAL** 

S. ------ SEEL 2 D. 101

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 2 1 7 0 Certificate of Death

			Certificate of			g. No.	G 1 1 7 0		
Physicia	เท	Decedant's Nama (First, Middla, Last)			2. Data of Death Month	Day Yas	3. Time of Death		
/Medic	al	Sandra Beatrice Meshorer  4a. Facility Nama (If not institution, giva streat and number)		4b. City, Town, or Lo	07 03 cation of Death	1999 4c. County of D	9:300A.		
	Ш	Genesis Elder Care Nursing	Anne A	rundel					
Funeral Director		5. Social Sacurity Number  0 2 8 0 1 2 1 6 1  Usual Rasidanca of Dacedant	Months Days		8. Data of Birth (Month, Day, 06 19	Year) 9.1 1917	Birthplaca (Stata or Foraign Country) MA		
28a-f show	2	10a. Stata 10b. County 10c. City, Town o	r Location				10d. Insida City Limits		
natural, or items 23a or 28a-f show	Director	MD Anne Arundel Sever	na Park				1 Yas 2 No		
0 0			10f. Zip Coda		10g. Citizan of What Country?				
rie 23a	Funeral	41 W. McKinsey Road.  11. Marital Status  12. Was Decedant Evar In U.S.	2114		city Yas or No-	USA 14 Bace - A	marican Indian.		
2.1	Completed by Fur	Armed Forcas?  1 Navar Married 2 Married 1 S S S S S S S S S S S S S S S S S S	13. Was Dacedent of H If Yas, specify Cuba 1 ☐ Yas 2 ☑ No		Rican, atc.)	Black, W	hita, atc.		
natural deal Ex		15. Decadant's Education 16a. Decadant's Edu	acedent's Usuel Occup	pation	1	6b. Kind of Busina	ss/Industry		
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ther than	Co		irector c	of Volun	teers	Hospit	a1		
8	Be	17. Fathar's Nama (First, Middla, Last)		18. Mothar's Nama	(First, Middla, M	laiden Sumama)			
To stic	2	To Be	ToB	Max Sandler		Racha	el Prim	nack	
9 10			Mailing Addrass (Straat						
NF				ny Briago			, MD 21122		
- b		1  Burial 2  □ Cramation 3  □ Ramoval from Stata 4  □ Donation 5  □ Othar (Specify)  Mt. Si	isposition (Nama of cramatory or other place nai Mem.	Park 7	/6/99 I	-	eles, CA		
Important: I any injury o		21. Signatura of Funaral Sarvice Licensaa  Marshall	22. Nama and Addra Sterling- 736 Edmor	ass of Facility -Ashtom- ndson Av	Schwab e. Cato	Funeral	Home Inc.		
	7	23a. Part1. Entar tha disaasa, or complications that caused tha death. Do not shock, or heart failure. List only one cause on each line.	antar tha moda of dyir	ng, such as cardiac o	r raspiratory arra	st,	Approximata Intarval Batween		
sician							Onset and Death		
ledical aminer		tmmedleta Causa (Final disaasa or condition CO Nas + + Ve	heart	tailu	re		years		
	_	resulting In death)  a. Jua to (or as a con	nsaquanca of):				1		
sit.	Examiner	tmmedieta Causa (Final disaasa or condition resulting in daath)  a	cardio	myopo	ithy		years		
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burie	<u>e</u>	Sequentially list conditions, if any, laading to Immadiate cause. Entar Undarlying Cause (Disaasa or Injury							
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for	Clar								
ched	ly Si	Part II. Other significant conditions contributing to deeth but not resulting in the	a undarlying causa giv	van in Part I.			ite to the cause of death?		
should be detached for use	Dy P	peripheral vascular disease	, demen	ntia,	1 🗆 Ye		Probably 4 Unknown		
00 CV	Completed by Physician/	color cancer, wherine			24a. Was an perform		b. Wara autopsy findings avallabta prior to complation of ceusa of death?		
s cartificata has t director, page 2 s	5	rectoroginal-enterovericula	v fistale	20	1 🗆 Yas	2 No	1 ☐ Yas 2 ☐ No		
artimo ector.	De	25. Was case refarred to medical exeminar?		26. Place of Deeth	(Check only ons	)			
al dire	0	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpa		4 Nursing Flor	na 5□ Rasidar	nca 8 🗆 Other (S	pecify)		
unera	0	27. Manpar of Deeth 1 Natural 5 Panding 28a. Data of Injury 28b. Tim (Month, Day Year) Injur	ry Wor		8d. Dascribe hov	w injury occurred			
the t	Certification:	2 Accident investigation 3 Suicide 6 Could not be 280 Place of Injury At home form		Yas 2 □ No					
n by		4 Homicida determinad 28a. Placa of Injury - At homa, farm, building, etc. (Specify)	straat, factory, offica	2	28f. Location (Str. City or Town,		Rural Routa Number,		
in in									
To the Funeral Director: After this cartificate he completely filled in by the funeral director, page	edical	29a. Cartifiar (Check only one)  (Check only one)	aath occurred at tha tin r Invastigation, in my o	ma, data and piaca, a plnion, daath occurre	nd dua to tha car ad at tha tima, da	usa(s) and mannar ta and piace, and d	as stated. lua to tha cause(s)		
oth	party.	29b. Signatura and titla of certifiar	29c. Licans	a numbar	29	d. Data signad (Mo	onth, Day, Year)		
- 8		1 must	71 -	DUIDS		7.2	50		
h	-			DT1 13	7	73	/1		
		30. Name and addrass of person who completed cause of daath (ttam 23a) (Tyr	pe, Print)	4100	1 0.	Lasta 1	arke 21:46		
		31. Date (itad (Month, Dey, Yaer) 32. Ragistrar's Stonature	Junger	1101416	ب علا	vevag r	ave MU		
State Registra	7	31. Date fitad (Month, Dey, Yaer)  32. Ragistrar's Stgnature	1						

DHMH 16 Rev 6/95



636 Oakland Hills Drive 1-A

15. Decedent's Education (Specify only highest grede completed)

North

Month July 1999 12:25PM 4b, City, Town, or Location of Deeth 4c. County of Deeth

Cecil

Perry Point If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) June 9, 19 Birthplece (State or Foreign Country) Hours 1915 Maryland

10d. Inside City Limits 1 Yes 2 No

2. Dete of Deeth

10f. Zip Code 10g. Citizen of Whet Country? 21012 United States

13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American indien Bieck, White, etc.

1 ☐ Yes 2K No Specify: White 18b. Kind of Business/Industry

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Tavern Owner Self-Employed

Rebecca

18. Mother's Neme (First, Middle, Meiden Sumeme)

Lingg 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Mrs. Concetta V. North - Wife 636 Oakland Hills Drive 1-A; Arnold, Maryland 21012

7/8/99

20b. Piece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition
1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Dete 20c. Location - City or Town, Stete

Lake View Mem. Park

21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility

Loring Byers Funeral Directors, Inc. 8728 Liberty Road; Randallstown, Maryland 21133

23e. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate intervei Between Onset end Deeth

unknown

Sykesville, Maryland

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

3. Time of Deeth

Immediate Cause (Final diseese or condition resulting in deeth)

resulting In deeth) Lest

3 Suicide

4 Homicide

Due to (or es e consequence ot)

Due to (or es a consequence ot)

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events

Due to (or es e consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

**Emphysema** 

12. Wes Decedent Ever in U,S. Armed Forces? 1∆1 Yes 2 □ No If Yes, Give Yeer or Detes: WW II

College (1-4or 5+) -0-

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Prostate Cancer

24e. Was en eutopsy performed? Bladder Cancer

28e. Pleca of injury - At home, farm, street, factory, office building, etc. (Specify)

24b. Were eutopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 ☐ Yes 2 ☐ No Stroke 25. Wes case referred to medical exeminer? 26. Plece of Death (Check only one) Hospital:

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be

🔀 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piece, and due to the cause(s) and menner as stated. 29a. Certifie:

Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and menner steted. (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture

.Mr D50454

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

Arastoo Yazdani, M.D. VA Maryland Health Care System Perry Point, MD

31. Dete filed (Month, Dey, Year 32. Registrer's Signeture State 06 1999 Sparker Registra

**DHMH 16 Ray 6/95** 

Division of Vital Records,

KNOWN TO PHYSICIAN: NORTH, HOWARD

Baltimore, Maryland 21215-0020

6 with

items 23a

natural', or

than

Important: if item 27 is marked ott any injury or other traumatic average.

Pi ysician i.iledicai

Examiner

attending physician and for use as the bunal-transit

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After this

Director: /

page 2 certificate has

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The lew requires that the death certificete be executed

or Attending Physician:

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24 hours a Hospital

within 2

Box 68760,

0.0

Physician/Medical Examiner

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Completed

Be

10

Certification:

edicai

al Hygie

death

efter

Funeral

à

Completed

11. Maritel Status

1 Never Merried 2 Merried

3 Widowed 4 Divorced

Elementery/Secondery (0-12)
7th Grade

Howard

17. Fether's Neme (First, Middle, Last)

4 ☐ Donetion 5 ☐ Other (Specify)

Box 68760. P.O. Records, Division of Vital

Baltimore, Maryland 21215-0020

**DHMH 16 Rev 6/95** 

Registrar

State

Radentz Stephen S 31. Date filed (Month, Day, Year) 5, 0 6 1999 JUL

30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

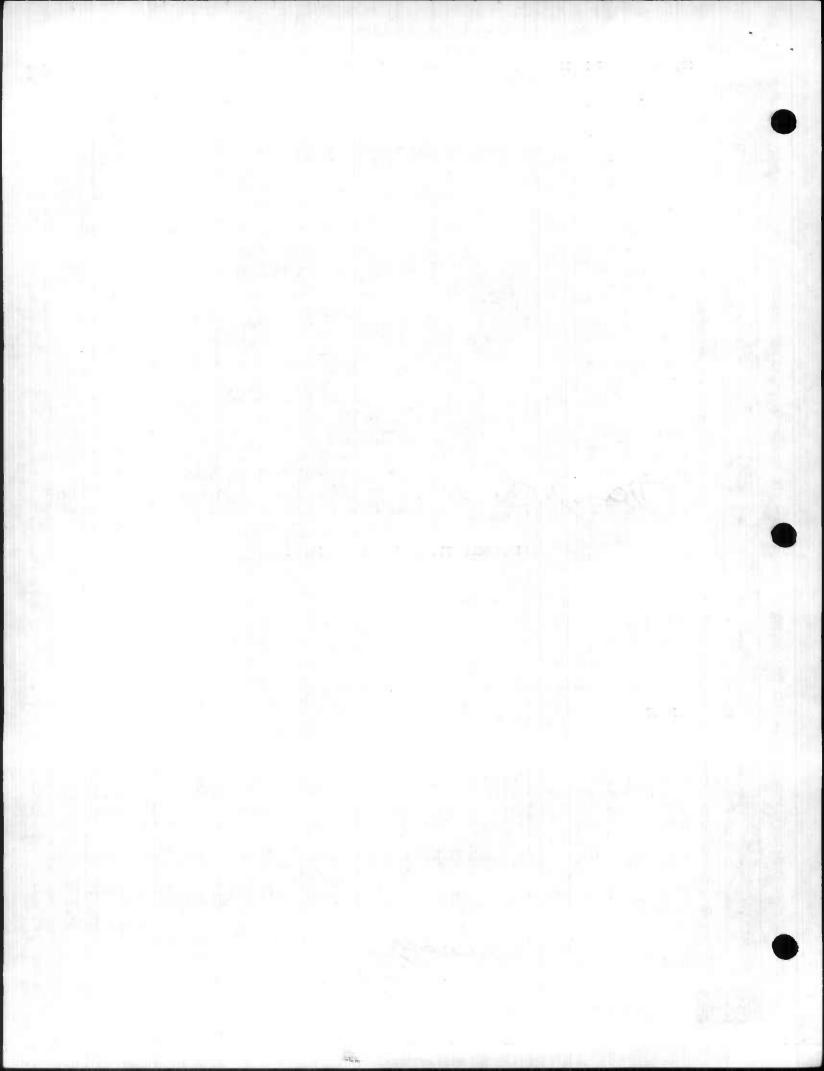
111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature porks

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 03, 1999



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

E	DWARD P	ERF	RY	State of Maryland	/ Department of I			giene Reg. No.	9 2	1173
	Diameter 1		1. Decedent's Nama (First, Middla, Las	)			2. Data of De Month	ath Day	Year	3. Time of Death
	Physici /Medi		EDWARD	>	PERA	RV JR.	JUNE	30, 199	9	2317 PM
	Examir		4e Facility Nema (If not institution, giva ST.AGNES HOSPITA			BALTIMORI		4c. County	of Death	12
	Funeral Director		5. Social Sacurity Number  6. Se  17-98-0800  19  Usual Residence of Decedent	7. Age (tn yrs. las	7 Yrs. H Under 1 Year Months Days	If Undar 24 Hrs. Hours Min.	8. Dete of Bir Month, Da		Counti	ace (Stata or Foreign
	yand how		10a. Stata 10b. County	10c. City,	Town or Location		•		10	d. Inside City Limits
	death with the Maryla errs 23e or 25e-f sho er mast be notified at	Director	MARYLAND Number	lA	BALTI 101. Zio Coda	MORE (	ITY	10g. Citizen of V	What Countr	1 XYes 2 No
	23a or			ORD AVENU		21216	, /	UC	SA.	
	des des	Funeral	11. Marital Status	12. Wes Decedent Ever in U,S. Armed Forces?		Hispanic Origin? (Sp	ecify Yes or No Rican, atc.)	- 14. Raci	- America k, Whita, e	
050	rs she	by Fu	1/S Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yas 2 2 No If Yas, Giva Yeer or Detes:	1□Yas 2⊠No	Specify:	7110411, 4101,	Specify		p-1 V
5-0020	72 hou natura Scal E	Completed	15. Decedent's Edi (Specify only highest grad	ucation	16a. Decedent's Usual Occuj (Giva kind of work dona	pation during most of work	ina	16b. Kind of Bu	siness/Indu	istry
21	The state of	nple	Elamantary/Secondery (0-12)	College (1-4or 5+)	tifa. DO NOT use retire	d)				
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7	thould mark mark	2	EDWARD  19e. Informent's Name/Ralationship (T)		2RI SR.  19b. Mailing Address (Street	and Number or Bur	at Routa Numb		KEL Stata Zio	
Ž	ond 2 s		WANDA PERRY		42160AKI					,
re,	Han offe		20a. Mathod of Disposition	20b. Pled	ce of Disposition (Nama of natary, crematory or other pla		Date	20c. Location	City or Tow	m, Stata
Ĕ	Page national		1 Buriel 2 □ Cramation 3 □ I 4 □ Donation 5 □ Othar (Specify,	Hamoval from Stata	G MEMORIAL A		7-06-99	WARD	A-11)	NARYLAND
alti	mit. spartings by Inji		21. Signature of Funerei Sarvice Licens	100	22. Name and Addre	ess of Fecility	and T	e. FUNE	PAI	HAME
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8760,	cate be shysicia the bur	dicai	Cause (Disease or injury that initiated events	c. Due to (or a	s a consequence of):				11	
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	the att	sici	Part II. Other algorificant conditions co	ntributing to death but not rasulti	ing in tha underlying cause gi	ven in Part I.	23b. Dld	tobacco use cor	ntribute to	the cause of death?
P.O.	d by the						10	Yes 2000	3 Prob	ably 4 Unknown
ds,	taw requires that es been signed to 2 should be deta	d by					Dia Man		24h Was	re autopsy findings
Ö	need	etec					perfo	an autopsy emed?	ava	lable prior to
Rec	8 C/	Completed by					×			eath?
g	iclan: The certificate h irector, pege	ပ္	75. When some referred to modical				12	22	1/25	¥as 2□ No
5	Physician: r this certific and director,	o Be	25. Was casa rafarred to medical axaminar?	Hospital: 1 ☐ Inpatiant 2 ☑XEF	R/Outpatient 3 DOA	26. Place of Deat		ona) dence 6 ⊟Oth	as /Canaik	
ō	Phys eral di	n: To	27. Manner of Death	28a. Date of Injury   28	8b. Tima of 28c. Inju			how Injury occur		
o	Attending I or death. ector: After by the funer	atio	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Near)	2300 And 10	Yas 2 No	SHOT	DURING	ST R	OBBERY
Division of Vital Records,	or Attandation of Director:	Certification:	3 ☐ Suicida 6 ☐ Could not be determined	28e. Piace of Injury - At home building, etc. (Specify)	Λ .		28f. Location ( City or To			4 3
	trai or rai Dir lled in				Automobi	le !	500 B	IK SW	annh	tve, Baltime
	To the Hospital or Attending Physician: The is within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edicai		alcian: To the best of my knowle her. On the basis of examination						
	ithin of the mple	- I	29b. Signature and Superi certifier	and manner stated.	29c. Licens	se number		29d. Dete signe	d (Month. F	lay, Year)
	F > F 8		146/	P 1.1		O.C.M.E			1, 1	
		+	30 Name and	ompleted cause of death (Item 2					~, 1	
					1 Penn Street,	Paltimo	m Mar-	rland 11	201	
	250		JOHN E. SMIALE	( M ) 111	r rom succel	DOTITION	e, Mary	Tarki 21	401	

DHMH 16 Rev 6/95

ORIGINAL

1. Decedant's Nama (First, Middla, Last)

JOSEPH WASHINGTON PETERS

4a Facility Nema (If not Institution, giva street and number)

JUL

111 24

Registrar

DHMH 16 Rev 6/95

**Physician** 

/Medical

Examiner

	108	a. Stata	10b. County		10c. City,	Town or Location					10d. inside
tor	ı	MD.	N/	A		Ba1t	timor	e			1 XYa
Director	10e	e. Street and N	umber			10f.	. Zip Coda			10g. Citizen of V	What Country?
al		53	18 Waba	sh Ave			2	21.21.5		USA	
d by Funeral			rried 25 Merried	Armed For 1 Yas if Yes, Give	<sup>2□No</sup> Marine	If Yas,	ecedent of I specity Cub es 2 No	Hispanic Origin? ( ban, Maxicen, Pua Spacity:	Specify Yes or No rto Ricen, atc.)	o Ricen, atc.)  Blect  Specity:	
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Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2. Deta of Death Month

July

4b. City, Town, or Location of Deeth

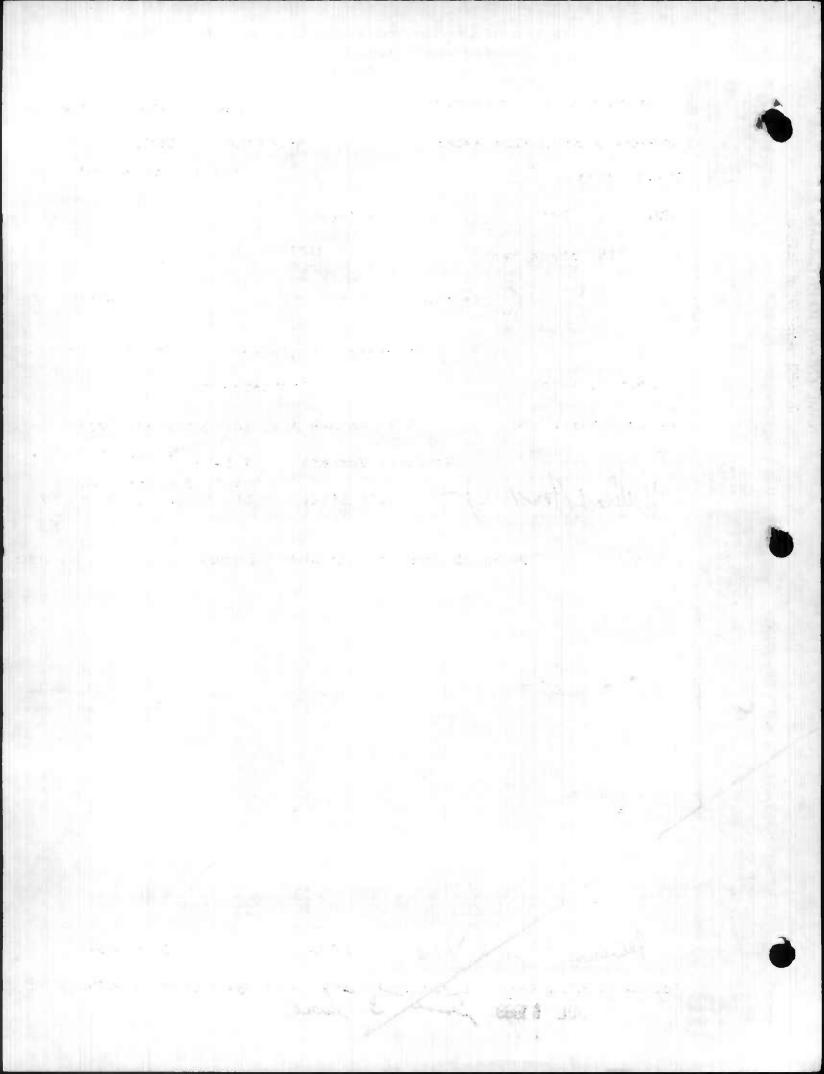
Day

1999

4c. County of Death

3. Time of Deeth

4:40 PM



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Year **Physician** July 2, 1999 5:11 P.M. Joseph J. Ryan /Medical 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner 2118 Northland Road Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) Aug. 15, 1917 9. Birthplece (Stete or Foreign Country) New York 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Deys Hours Yrs 054-01-2332 81 Director **Usual Residence of Decedent** 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits ahow Maryland Baltimore Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? rs 23a or 2 2118 Northland Road 21207 United States Funeral ltems 8 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 No. If Yes, Give WW II Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. Pages 1 and 2 should be filed within 72 hours effarment of Health and Mentel Hygiene. ant: If flem 27 is marked other than "natural", or its ury or other traumatic event, the Medical Exercition 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Plant Manager A & P Coffee 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Patrick Ryan Catherine Hayes 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Margaret M. Ryan - Wife 2118 Northland Road; Baltimore, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Buriat 2 Cremetion 3 Removel from State 20c. Location - City or Town, Stete Dete permit. Pages Department of H Important: If ite any injury or ot 4 ☐ Donation 5 ☐ Other (Specify) Vet. Cemetery 7/7/99 Garrison Forest, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Loring Byers Funeral Directors, Inc. Oh 8728 Liberty Road; Randallstown, Maryland 21133 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or bear failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Metestatic Small Cell Lung 1ears Examiner Brain metastesis Co months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Pue Physician/Medical å Due to (or es a consequence of): US0 88 signed by the at d be datached fo Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy lindings eveileble prior to completion of cause of death? 24a. Was an autopsy performed? page 2 certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director. Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide edical 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

The law requires that the deeth cartificate be executed Division of Vital Records, P.O. Attending Physician: ar or Attendenth. A 24 hour. Hospital 24 hours To the Hosp within 24 ho To the Fune completely f

deeth

Maryland 21215-0020

altimore.

Box 68760,

State Registrar

**DHMH 16 Rev 6/95** 

0 6 1999

(Check only one)

29b. Signature and title of contilion

31. Date filed (Month, Day, Year)

32. Registrar's Signeture

MO

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

iedmen

SHO

1838

B. Sports

Greenettee

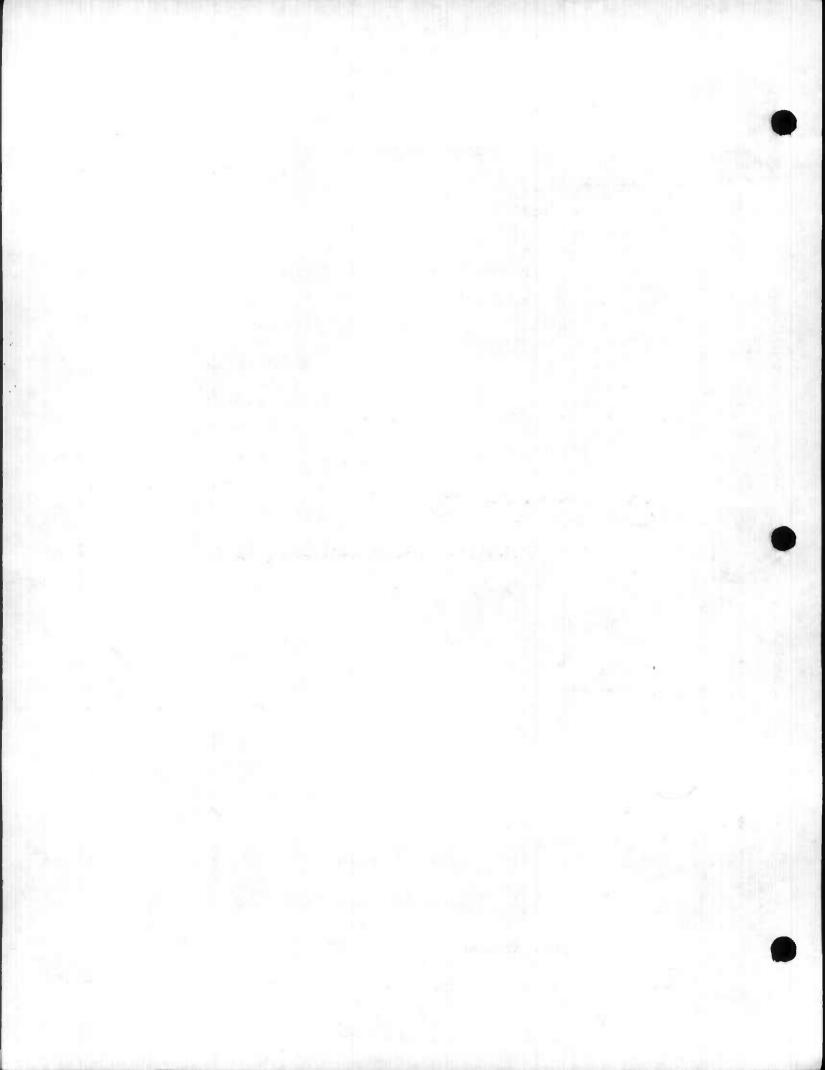
2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Rd. Str. 120 Baltimore, MO 21208

**ORIGINAL** 



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

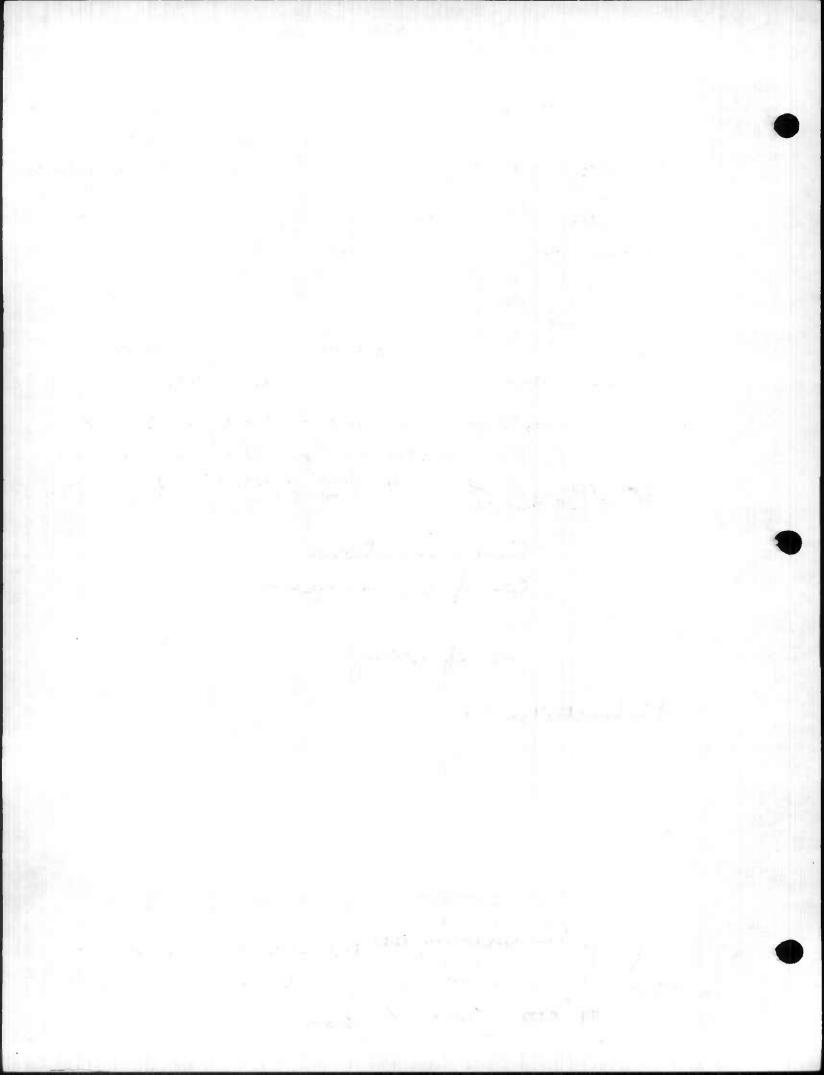
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Dey **Physician** Constance B. Richburg July 5, 1999 1:15 PM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 2433 Annor Court Baltimore If Under 24 Hrs. 8. Date of Birth Hours Min. AUG 24, 1933 5. Sociei Security Number If Under 1 Yeer 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign **Funeral** Deys 1□ M 2√ F North Carolina 245-40-8371 65 Yrs. Director Usuei Residence of Decedent filed within 72 hours after death with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at **Funeral Director** Yes 2 No N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ŏ 2433 Annor Court 21230 USA 23a нетв: 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No tf Yes, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Merital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0020 ŏ 1 ☐ Yes 2 X No Specify: þ Specify: Black 3 Widowed 4 Divorcad 'natural' Completed 15. Decadent's Education 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be Pages 1 and 2 should be finent of Health and Mental I sut: If item 27 Is marked of James Copeland Eloise Kelly other traumatic 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2: Department of Health as Important: If item 27 is any injury or other traugues. 2433 Annor Ct. 21230 James J. Richburg/husband Baltimore, MD 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 X remation 3 ☐ Removal from State Metro Crematory, Inc. 07/06/99 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Servica Licansee Cremation Society of Maryland, Inc. Edward A Gregorchik

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heert failure. List only one ceuse on each line. 299 Frederick Rd. Baltimore, MD 21228 **Approximate** interval Between **Physician** Onset end Deeth /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thet Initiated events resulting in deeth) Lest The law requires that the death certificate be exec P.O. Box 68760, Physician/Medical Due to (or es e consequence of): Pert It. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yas 2 ☐ No 3 Probably 4 Unknown Division of Vital Records, þ 8 Completed 24b. Were eutopsy findings eveileble prior to 24e. Wes en eutopsy completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attanding Physician: Be 25. Was case referred to medical exeminer? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) Certification: To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 ☐ Yes 2 No After this 27. Manner of Deeth 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation r death. 1 ☐ Yes 2 ☐ No 2 Accident the To the Hospital or Attand within 24 hours efter deati To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted.

Medical Examinar: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner steted. Medical 29a. Certifier (Check only one) 29b. Signatury 29c. License number 29d. Dete signed (Month, Dey, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) JorgeE 4000 Annapolis Rd Baltimore MD 2/227 alderon 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State

Registrar

DHMH 16 Ray 6/95



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 200 TUME 29 am BITHA RIDEOUT S. 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Deeth sultimore Tal reneral 8. Dete of Birth (Month, Dey, Year) July 23,1959 9. Birthpieca (State or Foreign Country) West Virginia fast birthday? 5. Social Security Number 10 M 20 F Months Deys Hours Min 234 08 9727 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limita Tes 2 No n/a Baltimore Maryland 10e. Street end Number 10g. Citizen of Whet Country? 10f. Zip Code 410 W. Franklin St. 21201 United States Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yea or No-if Yes, specify Cuben, Maxicen, Puerto Rican, etc.) Rece - American indien, Bleck, Whita, etc. 11. Maritel Status 1 ☐ Yes 2 🛣 No If Yes, Give Yaar or Datas: 1 Never Married 2 Married White 1 Yes 2 XNo Specify: 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 18e. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Induatry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker 9 17. Father's Name (First, Middle, Last) 18. Mothar'a Nama (First, Middle, Meiden Sumeme) Oxford Ceci1 Mary Ann Hill 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Code) Rinda Stanfield / Aunt 1931 Wilkens Ave., Baltimore, MD 20b. Plece of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremetion 3 ☐ Removal from State Green Mount Crematory 7/3/99 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD 22. Name end Address of Fecility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 23a. Pent1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or raspiretory arrest, shock, or haar failura. List only ona cause on each lina. Approximete intervel Between Onset end Death Intracerebral Bleed (Subarachnoid Hemorrhage) immediete Ceuse (Finel disease or condition resulting in deeth) Ruptures Sequentielly list conditions, if eny, leeding to immediate cause. Entar Underlying Causa (Disease or Injury that initieted evants resulting in deeth) Last Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 3 Probably 4 D Onknown 1 Yes 2 No 24b. Wara autopsy findings evallable prior to completion of cause of daeth? 24e. Wes en autopsy performed? 1 Yaa 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only ona) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Data of injury (Month, Dey Yeer) 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be datermined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Piece of injury - At home, ferm, street, factory, offica building, atc. (Specify) 4 | Homicide

requires that the death certificata be executed P.O. Box 68760. Division of Vital Records,

physician and the bunal-transit 82 980 for signed by tha a d be detached t paga 2 s has cartificate or Attending Physician: After this funaral daath. aftar daati Director: filled in by 24 hours a Funeral D Hospital within 2 eg: 2

**Physician** 

Examiner

**Funeral** 

Director

7 is marked other than "natural", or items 23s or traumatic event, the Medical Examinar must be

Pages 1 and 2 should be filed within 72 hours after death tent of Health and Mental Hygiena.

of Haalth

**Physician** 

/Medical **Examiner** 

Examiner

Physician/Medical

by

Completed

Be

Certification: To

edical

29a. Certifies

(Check only one)

b

the Manyland r 28a-f show

/Medical

Directo

Funeral

by

Completed

Registrar

DHMH 16 Ray 6/95

31. Date filed (Month, Day, Year)

29b. Signeture end title of certifies

Gil,

m.D.

30. Nama end addrass of person who completed cause of deeth (Item 23a) (Type, Print)

0/0

MD

32. Ragistrar's Signatura

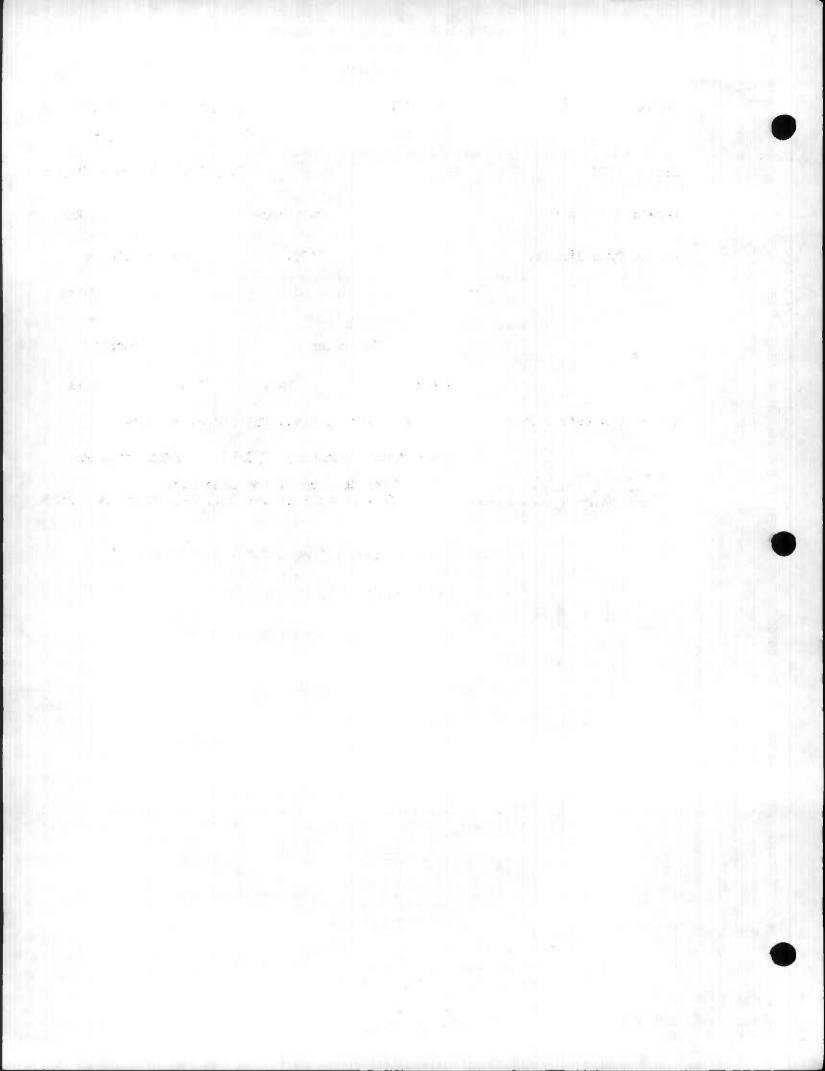
maryland General

11 Certifying Phyaician: To tha best of my knowladga, death occurred at tha time, data and place, and due to the ceuae(a) end manner as stated.

2 Medical Examinar: On the basia of examination end/or investigation, in my opinion, daath occurred et tha time, date end pleca, and due to the cause(s) end manner stated.

29d. Date signed (Month, Dey, Year)

59



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

SPA	NN  1. Decedent's Name (First, Middle, La	net)	Cei	rtificate of	Death	2. Date of De	Reg. No.		3. Time of Death
cian dical	MARK D	SPANN, I	I			Month JULY	1, 1999	Year	0145 AM
iner	4a Facility Nema (If not institution, given 3600 ARCHENTRO)				4b. City, Town, or L BALT IM		4c. County	of Death N/A	
al or	216-70-1040	Sex 7. Age (In 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	yrs. last birthday) Yrs.	If Under 1 Yeer Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Bir Month, Da 08/16	19 80°	9. Birthp Coun	lace (State or Foreign try) MD
	Usual Residence of Decedent  10a. Stete 10b. County	100	c. City, Town or Lo	cation				1	Od. Inside City Limits
Director	MD	N/A	ВА	LTIMORE					1☐Yes 2☐No
Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Coun	itry?
Completed by Funeral Director	3424 HILLDALE PL  11. Meritel Stetus  1∑ Never Merried 2 Merried	ACE  12. Wes Decedent Ever Armed Forces?  1  Yes 2 No If Yes, Give	1	2121. Wes Decedent of H If Yes, specify Cub 1□ Yes 2√√No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	- 14. Rac	JSA e - Americ ck, White,	etc.
	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's E	Year or Detes:		AA dent's Usual Occup			16b. Kind of B	DL.	ACK
	(Specify only highest gra Elementery/Secondery (0-12)		(Give	kind of work done DO NOT use retire Stud	during most of world)	king	Educ	,	
	17. Fathar's Neme (First, Middle, Last	)			18. Mother's Nem	ne (First, Middle,			
10	MARK SPANN, SR.				CAROL V				
	19e. Informant's Neme/Reletionship ( CAROL V. TERRY/				and Number or Rul LE PLACE,				Code)
	20a. Method of Disposition  1  Burial 2  Cremetion 3  4  Donetion 5  Other (Special	Removel from State	Ob. Place of Dispo		ce) 1	Date 7/7/99	20c. Location -	City or To	wn, Stata
	21. Signeture of Funerel Service Lice		22		MORTON & JRENS ST.				
Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	b	to (or es a consecto (or es e	juence of):	nshet	vou			
Physician/M	Part ff. Other significant conditions of	ontributing to death but no	t resulting in the u	nderlying cause gi	ven in Part f.	23b. Dfd	tobacco use co	ntribute to	the cause of death?
by Phy						10	Yes Who	3 Prol	bably 4 Unknown
Completed							an autopsy ormed?	av	ere autopsy findings allable prior to mpletion of cause death?
Com						A	Yes 2□ No	10	Yes 2□ No
Be	25. Was case referred to medical exeminer?	Hospitel:		Ott	26. Place of Dee				
Certification: To	27. Menner of Death 1 Netural 5 Panding 2 Accident 3 Suicide 6 Could not b	28a. Date of Injury North Day Yea	10/2	28c. fnjur Wo 1	4 U Nursing H	28d. Describe	how injury occur	St-d	†
ai Certif	Homicide determined		STR	CET	me, date end place.	3600 /	Tuckent	rdy	Temee
Medical		niner: On the basis of example and menner steled.		vestigetion, in my o	ppinion, death occur			and due to	Day, Year)
tate		completed cause of death	111 Pen		, Baltimo	re, Mary	yland 21	201	

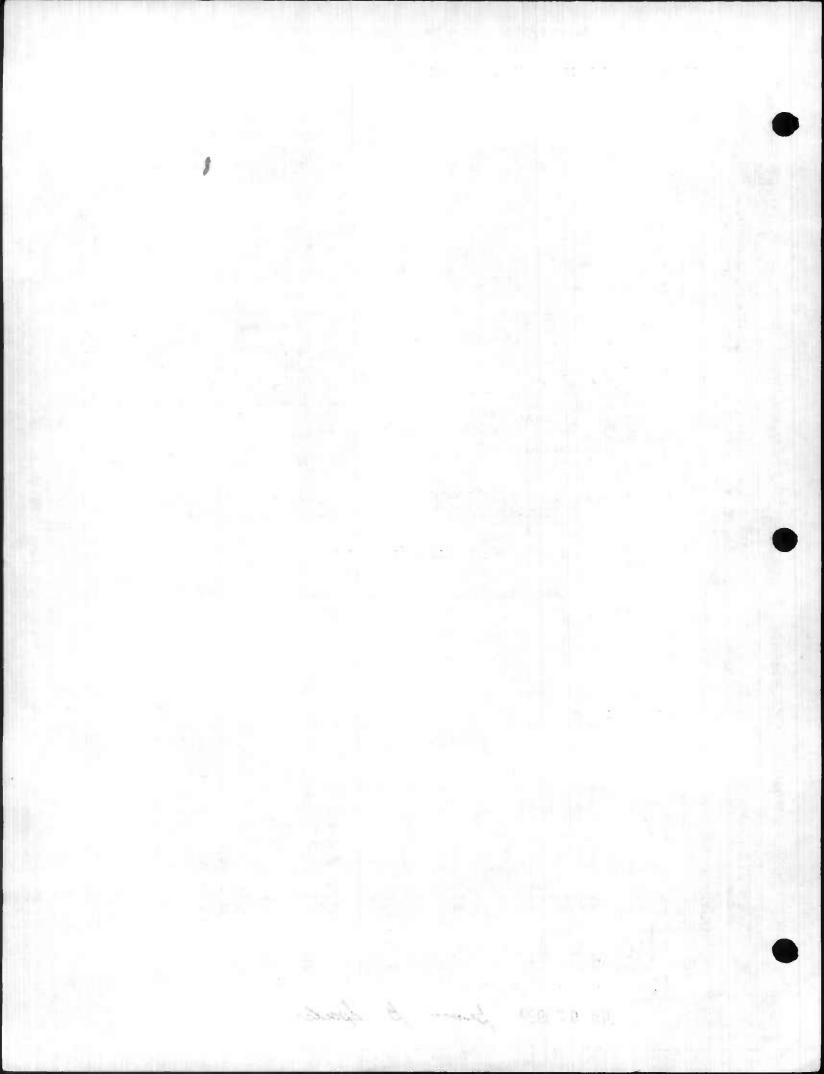
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SI	HAW AMEN	D I	TEMS: #23 PART I, II, 2	7 PER MEO G	aryland / Dep 3774 8-11-9 <b>Ge</b>	ertificate of	Death		eg. No.	) (	11/2
1	Physici		1. Decedent's Nama (First, Middla, Last	Ch	2/1)			2. Data of Deat Month	Day	Yaar	3. Tima of Death
Š	/Medic Examir		4a Facility Nama (If not institution, giva	street and number)			4b. City, Town, or Lo	JUNE ocation of Death	30°, 19	999 of Death	7:31P.M.
	LXaiiiii	ici	MERCY MEDICAL CENT	ER			BALTIMORE	Ξ		NA	
	Funeral Director		dan. 26.100 d	x 7. A( M 2□ F	ge (In yrs. last birthday, 57 Yrs.	If Under 1 Year   Months   Days		8. Data of Birth (Month, Day,	Year) 2	9. Birthp Cour	placa (State or Foreign
	yland		Usual Rasidance of Dacedant  10a. Stata 10b. County		10c. City, Town or L	ocation				1	10d. Inside City Limits
	Pa-fall	Director	MD N/A	}	Balt	MORE					1 Yas 2 No
	deeth with the Meryland rms 23a or 28a-f ehow rms to notited at	ral Dire	10e. Street and Number 1731 Tho	mas f	AVE .	10f. Zip Code	216	10g. Citizen of What Country?			
020	or its	by Funeral	11. Marital Status  1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yas 2 If Yas, Giva Yaar or Datas:		Was Decedent of If Yes, specify Cut  1 ☐ Yes 2 ☐ No	Hispanic Origin? (Spoan, Mexican, Puarto Specify:	ecify Yas or No- Rican, atc.)		ck, Whita,	can Indian, atc.
5-0020	72 ho	ted	15. Decedent's Edu (Specify only highast grad	cation	16a. Dece	dent's Usual Occu	pation during most of work	ina	16b. Kind of B	usinass/In	dustry
21	- 4 30	Completed	Elamantary/Secondary (0-12)	College (1-4or	5+) / Wa.	DO NOT use retire	during most of work	me	MONIS:	Heur	Harl
Id 21	202	To Be Co	17. Fathar's Nama (First, Middla, Last)	0	1 001	STRUCT	18. Mother's Name	a (First, Middle, M	Maiden Suman	na) /	7.7014
yiar			ANDREW ShA	ru J	R		INE	Z Ar	NEES	NC	
, Maryland	s 1 end 2 sho if Health and Item 27 ie m other traum		19a. Intormant's Name/Ratationship (Ty ANDREW Shr.	pe, Print)	0. 19b. Mail	ing Address (Stree	and Number or Run	AVE L	Baltino	Stata, Zip	Code) 21216
Baltimore,	A D		20a. Mathod of Disposition  1 Burial 2 Cramation 3 F  4 Donation 5 Other (Specify)	lamoval from State	20b. Place of Disp cematary, cre Ut. Z/	osition (Nama of matory or other pla	etely ?	Data 1/6/99	Balt	INDE	et
Balt	permit. Page Department of Important: If eny injury or		21. Signature of Funaral Sarvice Licans	Mo	rlyn 1	2. Name and Addr	ass of Facility	~ 7.H.	1701 4	LUCK	VSt E. Ud 2121'
			23a. Part V. Entar the disaasa, or compt shock, or haart failura. List only or	ications that cause na cause on each li	d tha death. Do not en	iter the mode of dy	ing, such as cardiac	or raspiratory arra		77,602	Approximata Intarval Between
	Physician /Medical		Immediata Causa (Final disaasa or condition	HYPER	TROPHIC CARDI	OMYOPATHY					Onset and Death
П	Examiner		rasulting in death)		Dua to (or as a conse					1	
Т	beto bush	Examiner		o. ————	Due to for our						
68760,	cate be executed physician and s the burial-transit	dical Exa	Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Disaase or injury that initiated evants	s	Dua to (or as a conse						. 3.2
Box 687	5 0 6	w	rasulting in death) Last	i	Due to (or as a consec	quence of):				1	
	the etter	Physician/M	Part II. Other significant conditions con	tributing to death b	out not resulting in the u	underlying causa gi	iven in Part I.	23b. Did to	bacco usa co	ntributa te	o the cause of death?
P.0	T 70 00	y Phy	SCHIZOPHRENIA					1 🗆 Y	2 2 No	3 Pro	bebly 4 Unknown
Records,	been si should	Completed by						24a. Was a perform	n autopsy ned?	av co	are autopsy findings allable prior to impletion of cause death?
- R	P e e	Com						184	s 2 No	1	Yas 2 No
Vital	Physicien: The lath this certificate he ral director, page	Be	25. Was casa rafarred to medical axaminar?	lospital:		-	26. Place of Deat	h (Check only on	a)		
o	Phys ral di	2	XXYas 2 No Canal No	28a. Data ot Inju	iry 28b. Tima d	III SLI DON		ma 5 Raside			(ע
ion	Attending Fire death.	atlor	1 Natural 5 Pending invastigation	(Month, Da	y Year) Injury		ork? ]Yes 2□No				
Division	2 4 2 5	Certification:	3 ☐ Suicida 6 ☐ Could not be datarmined	28a. Place of Inj building, at	jury - At homa, farm, st c. (Specify)	reet, factory, office		28t. Location (St City or Town	reet and Numl n, Stata)	per or Rura	al Routa Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physical Example (Check only one)	nician: To the best nar: On the basis of and manner st	of my knowledge, deat f axamination and/or in ated.	h occurred at the ti vestigation, in my	ima, data and place, opinion, death occurr	and dua to the ca red at the time, do	ausa(s) and ma ata and placa,	annar as s and dua to	tated. o the cause(s)
	To the To the comp	M	29b. Sign, ture and titla of certifiar	help	le.	29c. Licen	se number		9d. Data signe		Day, Year)
			30. Nama and addrass of person who co		leath (Item 23a) (Type,	Print)	Street, E				21201
	Sta	te	31. Data filed (Month, Day, Year)	32. Registr	rar's Sinnatura						
	Registr	ar	JUL 0 6 1	999	enews &	4. Space	Ks				

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dev Month Physician Dorothy Schmitt 1999 July. 6:50AM /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 16 North Rolling Road Catonsville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthpleca (State or Foreig March 14, 1932 Pennsylvania Birthpleca (State or Foreign \_Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2ÅF Yes 211-24-2006 67 Director **Usual Residence of Decedent** the Meryland permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygians. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show with jury or other treumsde event, the Medical Example Treumsde and page. 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Catonsville 1 TYPS 2 NO Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 North Rolling Road 21228 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: White aitimore, Maryland 21215-0020 1 Yes 2 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 8 Frank Horvath Theresa Windisch 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward D. Schmitt (Husband) 16 North Rolling Road, Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery Baltimore, Maryland 4 Donation 5 Other (Specify) 17/8/99 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licens 1630 Edmondson Avenue, Catonsville, MD 21228 Lenner 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervat Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner ettending physicien and for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) algned by the e Part IL Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown COPO 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 ☐ No certificate Division of Vital be or Attending Physicien: To sefer deeth.

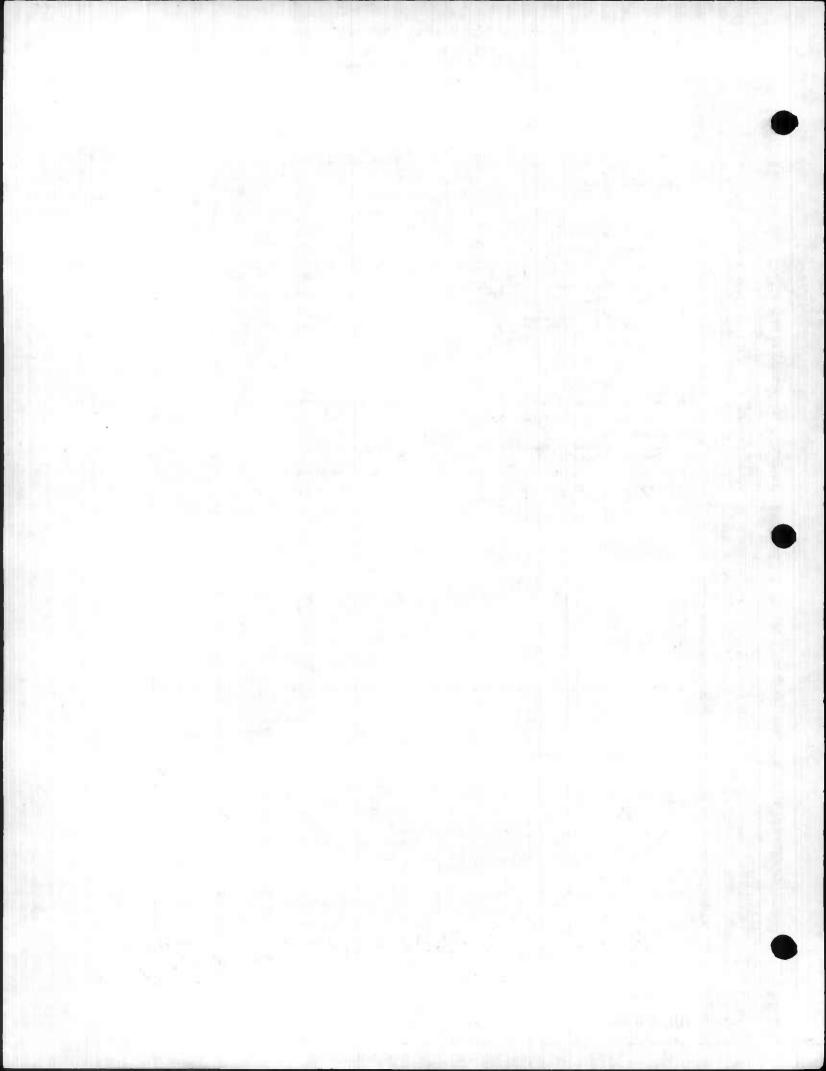
Si Director: After this centilicated in by the funeral director, pa 25. Was case referred to medical 8 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of De 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending 1 Natural 1 Yes 2 No 2 Accident investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Hornicide To the Hospital or within 24 hours eft To the Funerel Di completely filled in 13d Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner es stated.

2 | Sedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. edical 29a Certifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 024356 St Agnes Concer Center Cafon Ace Bolt and address of person who completed cause of death (Item 23a) (Type, Print) WMC. WAZENFIELD mo

State Registrar 31. Date filed (Month, Day, Year)

**DHMH 16 Rev 6/95** 

32. Registrar's Signature



### Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dele of Death Month 3. Time of Death Year **Physician** June 30, 0:35 p.m. 1999 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthdey) **Funeral** Deys Months Hours 1 M 2 F Yrs Director Usual Residence of Decedent the Maryland 10a. State Town or Location 10d. Inside City Limits nen zr is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo 10e. Street and Number 10g. Citizep of What Country? Funeral 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Stetus 1 Yes 2 H If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 1 No Specify ģ 3 Widowed 4 Divorced Completed which known as 16a. Decedent's Usuel Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 17. Father's Neme (First, Middle, Last) e. Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked of 2 0 la 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20a Method of Disposition cemetery, cremetory or other pla 1 Buriai 2 Cremation 3 Removei from Stete 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Faci 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Pneumonia/Pulmonary Alveolar Hemmorhage Examiner Due to (or as a consequence of): Myelodysplastic Syndrome Exami Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): and Gastrointestinal Bleeding physician Physician/Medical Due to (or as a consequence of): å Supra Ventricular Tachycardia 2 860 Part ff. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 8 1 Yes 2 No 3 Probably 4 Unknown egned by Pulmonary Embolism þ 盂 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? Pass **D808** 2 2 0 No 212 No 1 Yes certificate Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA all a 27. Manner of Death Date of Injury (Month, Dey Year) 28c. fnjury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Netural 5 Pending 1 Yes 2 No 2 Accident investigation after dealf Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Certifier (Check only one) Š 29d. Date signed (Month, Day, Year) 29b. Signature and title of cooffice 29c. License number July 1, 1999 P12303

Registrar

State

dita ....

6 1999

Neme and address of person who completed cause of death (Item 23e) (Type, Print)

Jeanee M. Barnes
31. Date filed (Month, Dey, Year)

32. Registrar's Signeture

2401 W. Belvedere Avenue

B. Sparks

Baltimore, MD 21215-5271

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 2. Data of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 755AN Month **Physician** Effie I. Stitley July /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner N/A Stella Maris at Mercy Hospital Baltimore if Under 1 Year | If Undar 24 Hrs. 7. Aga (In yrs. lest birthday) Birthplaca (Stete or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Dey, Year) **Funeral** Days Months Hours 1 ☐ M 2 🔀 F 219 18 3535 72 Director Sept. 28,1926 Connecticut Usual Residence of Dacedent with the Meryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yas 2 No Directo Maryland Halethorpe Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code Apt. 306 21227 U.S. 200 - 1st Avenue Funeral deeth permit. Pages 1 and 2 should be filed within 72 hours effer deel Department of Health end Mental Hygiens. Important: If item 27 is marked other than "natural" and any liqury or other traumatic event. 13. Was Dacadent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - Amarican Indian Black, White, etc. 12. Was Dacedant Ever in U,S. Armad Forces? 11. Marital Status 1 ☐ Yas 2 No 1 □ Navar Marriad 2 □ Married 1 Yes 2 XNo Specify: Specify: White þ 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Spacify only highest grade completed) (Giva kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Collage (1-4or 5+) Private Home Duty L.P.N. 8th 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) Be Mary Manley 70 Leonard Lugenbeel 19b. Mailing Addrass (Straat end Number or Rural Route Number, City or Town, Stete, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Goose Creek, S.C. 29445 W. Leonard Martinoli / Son 115 Salina Lane 20b. Placa of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Mathod of Disposition Date 1 Burial 2 Cramation 3 Removal from State 7/3/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Holy Cross Cemetery 22. Nama and Address of Facility 21. Signature of Funaral Sarvice Licensee Gonce Funeral Home P.A. Baltimore, Md. 21225 4001 Ritchie Highway ranerouske Approximate fnterval Between Onsat and Death cations that causad the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, 23a/Part1 Physician Immediate Cause (Final disaase or condition resulting in daath) /Medical Examiner Physician/Medical Examiner ettending physicien end for use as the bunel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaasa or Injury that initiated events resulting in death) Last Dua to (or as a conse The law requires that the death certificeta be execu Division of Vital Records, P.O. Box 68760, Dua to (or as a consequenca of) the use as t 23b. Did tobacco use contribute to the cause of death? signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably Inknown 1 Tes 2 No þ 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Completed peed completion of cause of death? certificete has lirector, page 2 : 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: 24 hours after death. 26. Placa of Death (Check only ona STE / A MARIS 25. Was case raferred to medical AT MERC Be examiner? Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Hospics 1 Yas 2 No Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 2 this Mangar of Death 28d. Dascribe how Injury occurred 28a. Data of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Certification: After 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No by the 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28a. Placa of Injury - At home, farm, straat, factory, office building, etc. (Specify) 4 Homlcide ă To the Hospital within 24 hours a To the Funeral Completely filled TET Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the best of axamination and/or invastigation, in my opinion, death occurred at the tima, dete and place, end dua to the cause(s) and manner stated. 29a. Certifier edical (Check only 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) 21202, DAVID RISE BERG PAUL BALTIMORE

**DHMH 16 Rev 6/95** 

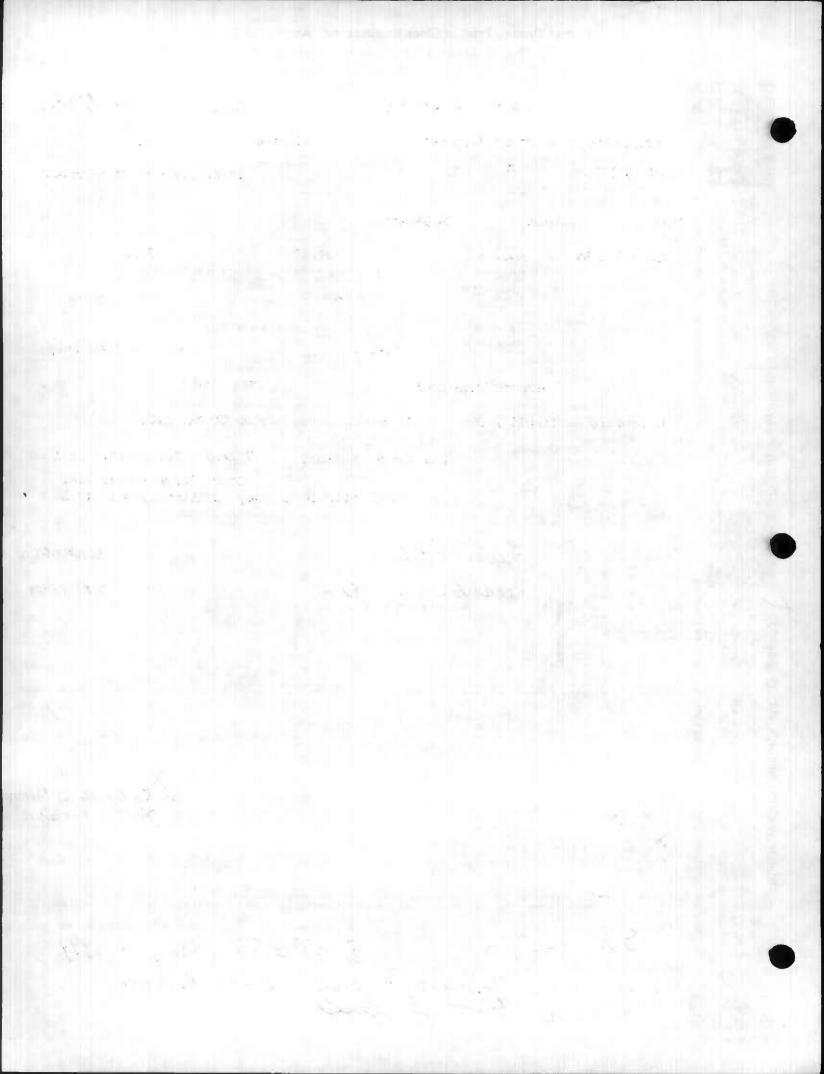
State

Registrar

31. Date filed (Month, Dey, Yeer)

JUL 0 6 1999

37. Ragistrar's Signature



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth schlee Month 1:15 A.M. av. June 30 1999 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth 2935 Guilford **Baltimore** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months **₩** 2□ F 219-30-0976 Yrs. 64 August 15, 1934 Maryland Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 Yes 2 No N/A **Baltimore** 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2935 Guilford Ave United States 21218 12. Was Decadent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Biack, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give X Yeer or Dates: 1 ☐ Yes 3 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Hair Stylist Salon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Henry J. Schlee Marquerite A. Zeberlein 19a. Informant's Name/Relationship (Type, Print) Personal 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) William C. Martin/Representative 2505 Place of Disposition (Name of cametery, cremetory or other place) 2935 Guliford Ave Baltimore MD 21218 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 7-2-99 **Baltimore** 21. Signature of Funera 22. Name and Addrass of Fecility CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Part1. Enter the disease a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ohuman Approximate Interval Between Onset end Death 12 hours Immediate Cause (Final Myourant disease or condition resulting in deeth) YLAYS Hypertension Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) that initiated events resulting in death) Last Due to (or as a consequenca of) 23b. Did tobecco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to 24e. Was en eutopsy completion of cause of death? 1 Yes 2 No 1 Yes 2 No

**Physician** /Medical Examiner

The law requires that the death certificate be executed

attending

2

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Affer

efter death.

P.O. Box 68760.

Records,

Division of Vital or Attending Physician:

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Department of
Important: If it
eny injury or o

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

rei', or items 23a or 28a-f show Examiner roust be notified at

"naturel", or

Peges 1 end 2 should be filed within 72 ho nent of Health and Mentel Hygiene. Int: If Item 27 is marked other than "natur Iry or other traumatic event, the Medical

Director

Funeral

by

Completed

Be

MD

the Maryland

72 hours efter

Baltimore, Maryland 21215-0020

Physician/Medicai Examiner sician and buriel-transit physician the buriel the a signe bed by Completed page 2 director Be Certification: To funerai To the Mospital or Atterwithin 24 hours efter der To the Funeral Director completely filled in by the

Part II. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Part I

25. Was casa referred to medical 26. Place of Death (Check only one)

Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury et Work? 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how Injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) 29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

29c. License number 34680 29d. Dete signed (Month, Day, Year)

of person who completed cause of deeth (item 23a) (Type, Print) 30. Name and eddres

Randoph MD Michael 3333 N CALVERT ST HLSS BALT MD 21218

31. Date filed (Month, Day, Year) JUL 0 6 1999

1 Ves 2 No

Manner of Death

Natural

2 Accident

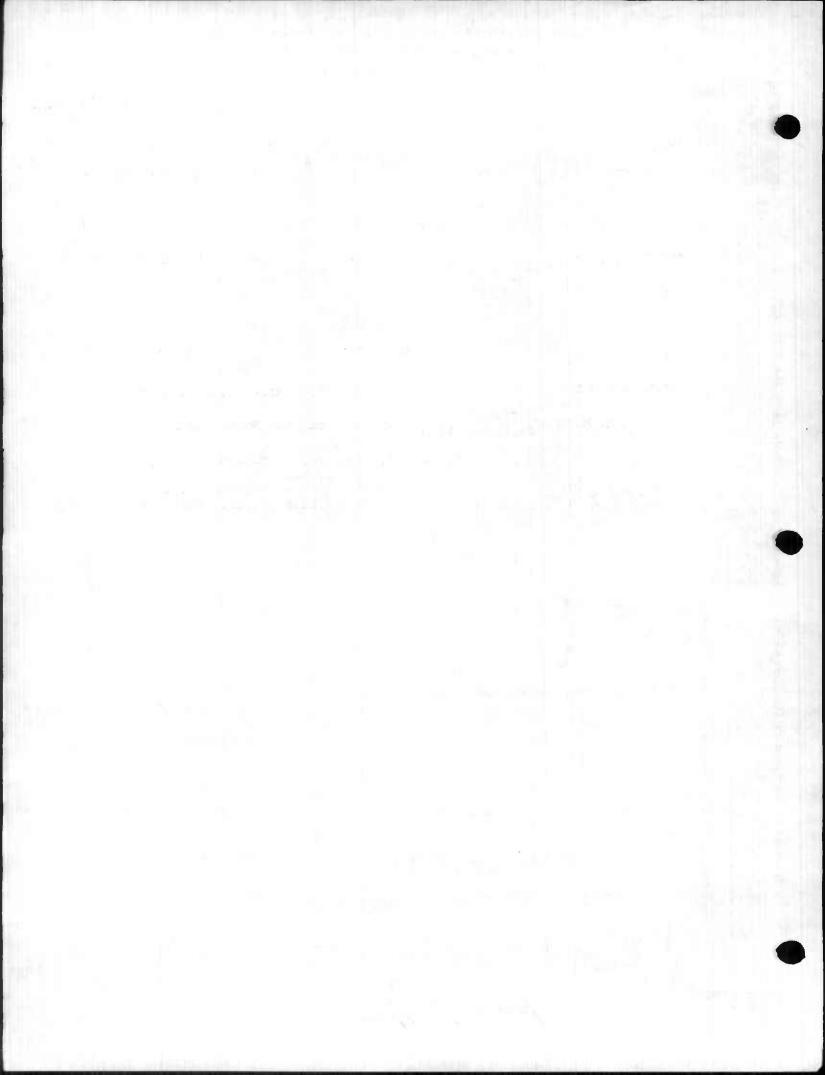
4 Homicide

3 ☐ Sulcide

29a. Certifier

32. Registrar's Signature

State Registrar

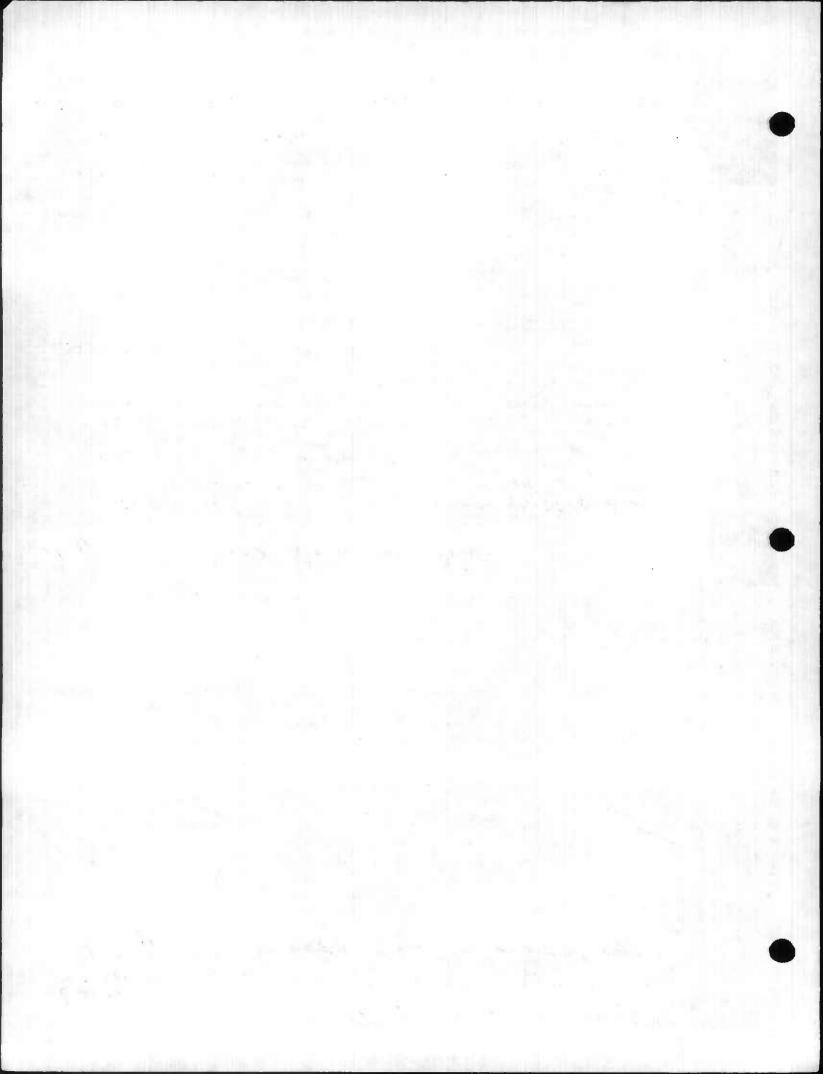


# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** GLORIA DIANE SCHATZ JULY 1999 7:10 AM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 501 Murdock Rd. Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Aga (In vrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) **Funeral** Days Months 1□M 2XF Hours 218 52 2016 49 Director Oct. 15, 1949 Maryland Maryland Usual Rasidence of Decedant 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Baltimore Baltimore Maryland 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 501 Murdock Rd. 21212 United States Herns 23s Funerai death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 Ø No ff Yes, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. 11. Marital Status filed within 72 hours after Hygiena. Wher than "natural", or its 1 Never Married Married Baltimore, Maryland 21215-0020 White 1 Yas 2 No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens important: if Nem 27 is marked other that any Injury or other traumatic entering once. Real Estate Agent Real Estate Office 12 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumama) Be Charles Knott Frances Ebbert 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Edward A. Schatz / Husband 501 Murdock Rd., Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - City or Town, Stata 1 Burial 20 Cramation 3 Ramoval from Stata 7/3/99 Baltimore, MD 4 ☐ Donation 5 ☐ Othar (Specify) Green Mount Crematory 22. Name and Address of Facility CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 Juann 23a. Part1. Entar the disaasa, or complications that caused the death. Do not entar tha mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset and Death **Physician** tmmediate Causa (Final disaasa or condition rasulting in deeth) /Medical Sveast 41 Examiner Dua to (or as a consequence of): Examiner The law requires that the death certificate be asscuted physician and the burial-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disaase or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760 Physician/Medicai Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 6 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yas 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; I Be 25. Wes casa rafarred to medicel axaminar? 26. Place of Deeth (Check only one) Hospitel: 1□ Yes 2□ No Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of Injury edical Certification: 28c. Injury et Work? 28d. Describe how injury occurred Division 1 Naturel 5 Panding invastigation 1 Yas 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be 3 ☐ Suicide Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicida 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Cartifiar (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and titla of certifiar 028239 , Chine mo 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 600 N Wolfest ancien7 Etophin Center 32. Registrar's Signatura 31. Data filed (Month, Dey, Year) State 0 6 1999 Registrar



4a Facility Name (If not institution, give 528 Gold Street 5. Social Security Number 6. Se	CHISHA  e street and number)  A Age (In)		RPELL	4b. City, Town, or I	2. Date of Deat Month  July ()  .ocation of Death	Day	Yeer 1:	me of Death
4a Facility Name (If not institution, gives  528 Gold Street  5. Social Security Number 6. Se  215 33 7857  Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimo  10a. Street and Number	ex   7. Age (In)	yrs. last birth	day) If Under 1 Yea	Baltimor	July ()	2, 1999	1:	19 P.M.
528 Gold Street  5. Social Security Number 6. Security Number 11  215 33 7857  Usual Residence of Decedent 10a. State 10b. County 10a. State 10b. County 10a. Street and Number	ex 7. Age (In )		Months Days	Baltimor	ocation of Death			IJ F.M.
5. Social Security Number 6. Security Number 215 33 7857  Usual Residence of Decedent 10a. State 10b. County Maryland Baltimo 10a. Street and Number	□ M 2XXF		Months Days				or Doub!	
215 33 7857  Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimo  10a. Street and Number	□ M 2XXF		Months Days				I/A	
Maryland Baltimo			3.		8. Date of Birth (Month, Day, Sept. 2	Year) 6,1976	9. Birthplace (S Country) Englan	THE PARTY
		City, Town	or Location	Baltimo	re			ide City Limits Yes 20(No
2705 Madricell CC.			10f. Zip Code	21209	1	og. Citizen of V Zan	Whel Country?	-
11. Meritel Stetus  12. Wes Decedent Ever in U,S. Armed Forces?  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes, specify Cuban, Mexican, P 1 Yes, Give 1 Yes, Give 1 Yes To Dates:								
(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done durilife. DO NOT use retired)				e during most of wor ed)	uring most of working			
			Stud	T	ne (First Middle N			
Robert N.								
the second secon			+11					
				en Ct., E				
20a. Method of Disposition  20b. Place of Disposition (Name of cametery, crematory or other place)  20c. Location - City or Town, State  20c. Location - City or Town, State  20c. Baltimore, MD								
23a. Part1. Enfer the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	CHRON	NIC N	8717 Gree t enter the mode of dy ARCOTISM	en Pasture ring, such as cardiac	es Dr., B correspiratory arre	altimon	Appro	21286 eximate al Between and Death
	b							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infiltated events resulting in death) Last	Due to (or as a consequence of):							
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Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of			
							eveilable	prior to on of cause
					1/2 Ye	s 2 No	1 Yes	2□ No
25. Was case referred to medical examiner?	Hospital:							
PE 165 ZE NO	28a. Date of Injury F (Mooth Clay Year) F 7 2 2 0 0  28b. Time of UNIVIOUN 1 28c. Injury at Work? 1 28c. 2 No			4 LI Nursing H				scene
1 Natural 5 Pending investigation								
3 ☐ Suicide 6 ☑ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) FOUND IN VACANT HOUSE				28f. Location (Street end Number or Rural Route Number, City or Town, State) 5 2 8 GOLD ST, BALTIMORE, MD			
29a. Cartifier (Check   (Chec	iner: On the basis of exam	knowledge, on hination and/	death occurred at the toor investigation, in my	time, date end place opinion, death occu	, and due to the ca rred at the time, do	ause(s) and ma ate and placa,	anner as stated. and due to the ca	iuse(s)
29b. Signature and title of certifier	and married stated.		29c. Licer	nse number	2	9d. Date signe	d (Month, Day, Y	ear)
	1 Never Married 2 Married 3 Widowed 4 Divorced  15 Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Robert N.  19a. Informant's Name/Retationship (7) Robert N. Serpell 20a. Method of Disposition 1 Burial MCremetion 3 4 Donation 5 Other (Specify 21. Signature Funcal Service Lieuth 23a. Part1. Enfer the disease, or composhock, or heart failure. List only of the composition of the compos	1	1 Never Married 2 Married 3   Married 3   Miros 20 Married 15. Decedent's Education (Specify only highest grade completed)   16a. [ Miros 20 Married 15. Decedent's Education (Specify only highest grade completed)   16a. [ Miros 20 Married 15. Decedent's Education (Specify Only highest grade completed)   16a. [ Miros 20 Married 15. Decedent's Education (Specify)   19b.   19c. Informant's Name/Retationship (Type, Print)   19b.   19b	1 Cytes 20No   2 Cy	1   New Warried   2   Married   1   Ves   2   2   No   Specify	1   Yes   20%   2   Yes   20%   2   Yes   2   Yes   2   Yes   2   Yes   2	10 Nervice of Married   Ma	1   Yes   20   No   Specify   Black   Specify   Specify   Specify   Black   Specify   Specif

State Registrar

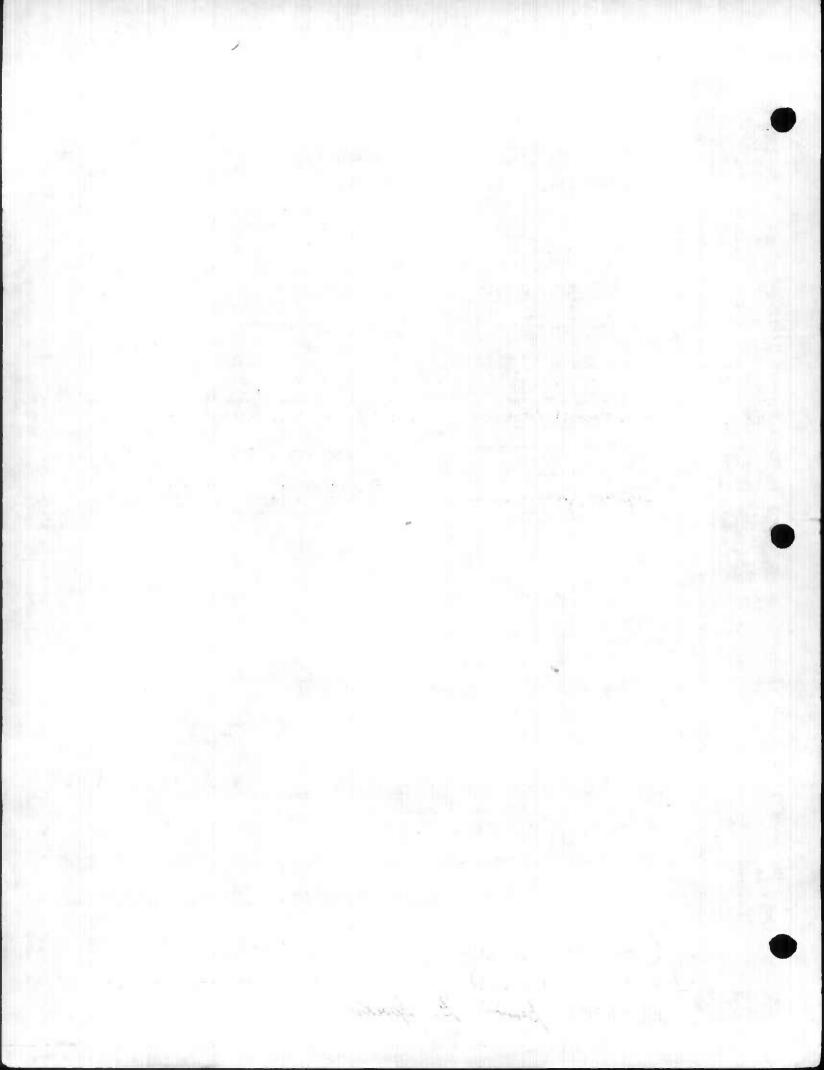
30. Name and address of person who complete the complete that the complete the complete that the compl

32. Registrar's Signature

eted cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 B. Sparks

DHMH 16 Rev 6/95



### Piease Type or Print in Biack indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 4:00AM DWAZI 14/0 /Medical 4b. City, Town, or location of V 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner N/A YOUKINS HEMORE VEEWI If Under 1 Yea If Under 24 Hrs. Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1⊠M 2□ F Hours 73 220-14-8690 Director Oct 31 Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahom permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglana. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 ahor any injury or other traumatic avent, ma Madical Examinar must be notified at Baltimore 1 Yes 25 No Director MD Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 511 45th Street 21224 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 20 Married Maryland 21215-0020 1 ☐ Yes 2 1 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steelworker Can manufacture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) 8 James Trawinski Bertha Gnatowski 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Lucy Trawinski 511 /wife 45th Street Baltimore, MD 21224 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Sacred Heart of Mary 1999 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Connelly Funeral Home of Dundalk 21. Signature of Funeral Service Licenses 7110 Sollers Point Rd 150 23a. Parf. Enter the dismuse, or complications that caused the dismuse. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examir the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): physician Box 68760 Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 2 ž Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. à 1 Yes 2 No 35 Repeably 4 Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 2 9080 certificate has 1 Yes ZNO 1 Yas 28 No 25. Was case referred to medical å 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: No Inpatient 2 EP/Outpatient 3 DOA 1 Yes 2 No 2 書 28c. Injury at Work? 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: if or Attending P after death. Director: After 1 Natural Injun 5 Pending 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral D edical TCCrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and the of certific 29c. License number 29d. Date signed (Month, Day, Year)

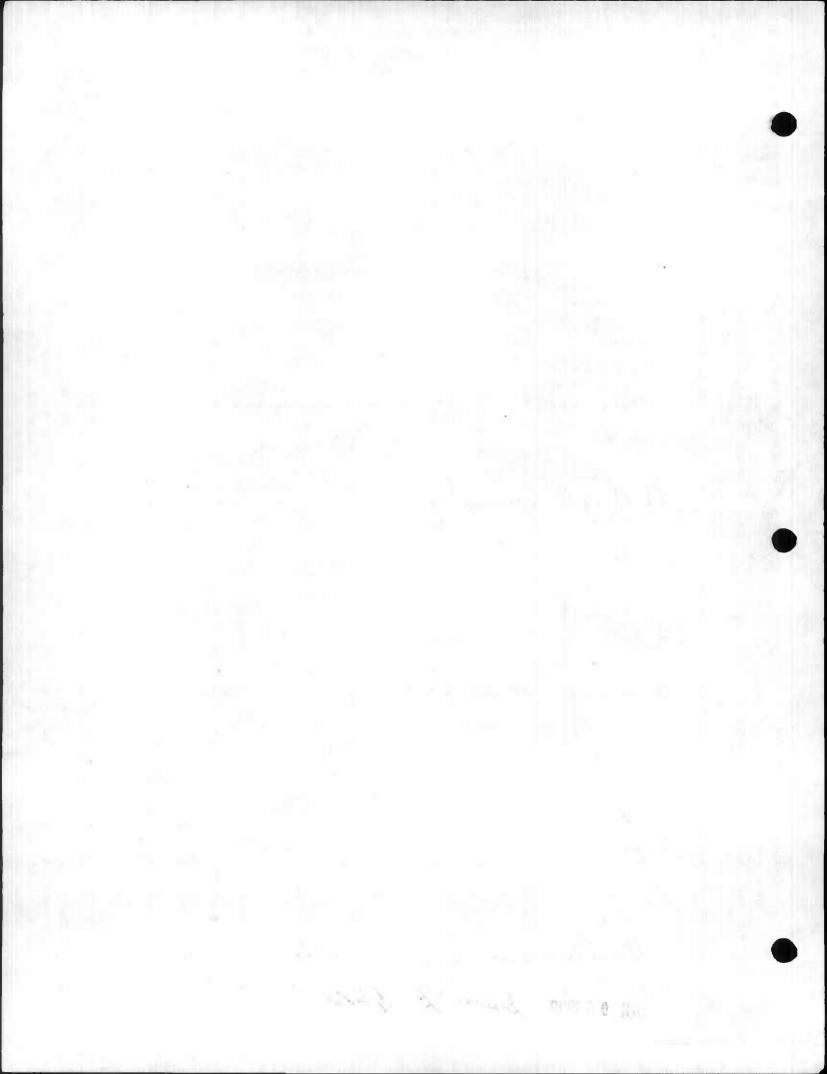
State Registrar

DHMH 16 Rev 6/95

Johns Hopkins

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BAYNEW MEDERALC



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HELEN	
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BEL	Certificate of Death	g. No.	9
CLEN	State of Maryland / Department of Health and Mental Hygic	ene a	0

UE 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Data of Death Month Day **Physician** HELEN M. UEBEL JUNE 30, 1999 8:02A.M. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7 OAK LANE GLEN BURNIE ANNE ARUNDEL H Under 1 Year H Under 24 Hrs. 8. Data of Birth Months Days Hours Min. 2/040ritb Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foreign W. VIRGINIA **Funeral** 1 M XXF 86 Director 216.40.1562 Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23s or 25s-f show the Medical Examiner must be notified at 1 Yas 2 No Director GLEN BURNIE ANNE ARUNDEL 9 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23s or 21061 U.S.A. 7 OAK LANE SW Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ Yo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - Amarican Indian Black, Whita, atc. hours efter 1 Never Married 2 Married aitimore, Maryland 21215-0020 1 Yes 2 XXio Specify: Specify: WHITE p 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) illed within 72 h Hygiene. other than "natu 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit.
Department of Health and Mental Hyglens important: if item 27 is marked other the any fillury or other treumatic event, that pages. HOMEMAKER OWN HOME 17. Father's Nama (First, Middle Last) 18 Mother's Nama (First Middle Maiden Sumame) Be MARY BERNOSKI ANTHONY MARCHLINUS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) MARY J. NEAL - DAUGHTER 536 VALLEYWOOD ROAD, MILLERSVILLE, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Vaurial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) HOLY CROSS CEMETERY 7/3 BROOKLYH MD 5 Other (Specify) 21. Signature of Funeral Service Licen FINK FUNERAL HOME, P.A. 22. Name and Address of Facility ulapu 426 CRAIN HWY., SW, GLEN BURNIE, MD 21061 KELLY GREGORY FINK 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. Line any one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final Antonosusporic CANDIOVASCULOR DISEASE diseasa or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician end the burlei-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or as a consequence of) for use es P.O. deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by d be detect 1 Yes 2 No 3 Probably 4 Unknown Records. à 24b. Wara autopsy findings available prior to complation of causa of death? been si 24a. Was an autopsy performed? Completed page 2 1 Yas 2 No 18 Yas 2 No certificate Division of Vital Attending Physicien: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 X Yas 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manger of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 PNatural 5 Pending death. 1 ☐ Yas 2 ☐ No investigation 2 ☐ Accident Director: 6 Could not be detarmined 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) ie Hospital or Attuna 24 hours effer di he Funerel Direct pletely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the causa(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29a. Certifier edical completely (Check only one) within 2 29c. License number 29b. Signature and title of certifie 29d. Data signed (Month, Day, Year) O.C.M.E. JULY 1, 1999 ss of person who completed cause of death (Item 23a) (Type, Print)

**DHMH 16 Rev 6/95** 

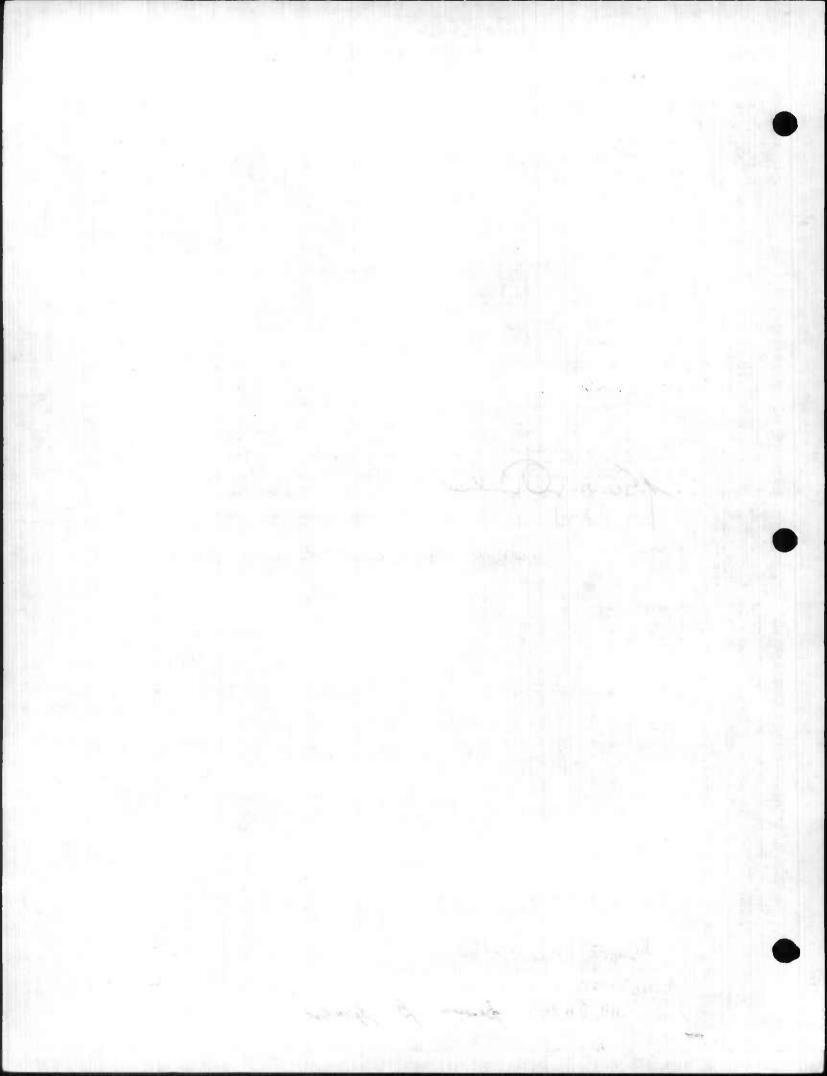
State Registrar

111 Penn Street, Baltimore, Maryland 21201

A. KORSU MM

32. Registrar's Signature

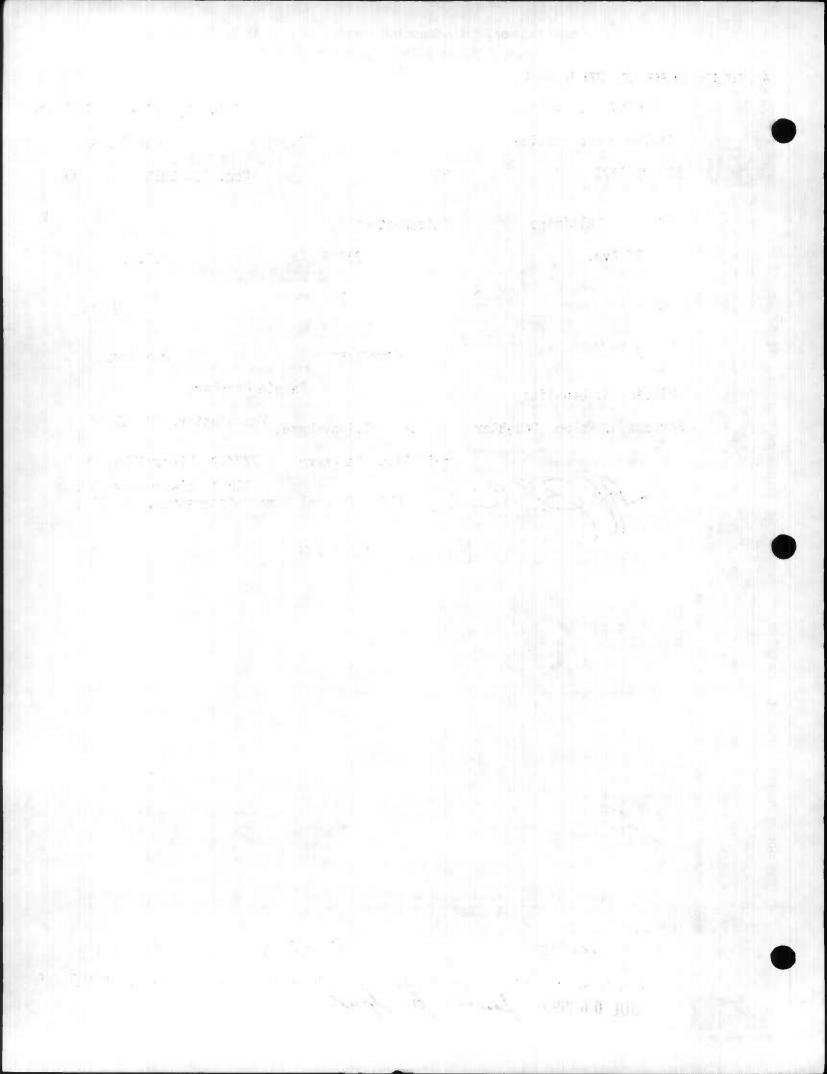
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death AMENDED ITEM #3 PER M.D. G773 7/6/99 AH 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) **Physician** DOROTHY B. 4, 1:42 p.m. 1999 July /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Stella Maris Hospice Timonium Baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number If Under 1 Year Birthplace (Stete or Foreign Country) 7. Age (In yrs. lest birthday) **Funeral** 1 M 2 XF Months Deys 216-01-4171 Yrs. 83 Director Dec. 12, 1915 MD Usuel Residence of Decedent with the Meryland 10d. Inside City Limits 10a State 10h County 10c. City. Town or Location 28a-f show 7 is marked other than "natural", or flems 23a or 28a-f shor traumatic event, the Medical Examinar must be notified at 1 Yes 2/ No Baltimore Reisterstown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6 Wolf Ave. 21136 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forceş? 1 ☐ Yes 2 Ø No If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Merital Stetus filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify. þ 3 Widowed 4 □ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Hyglene. Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filk Department of Health end Mentel Hy Important: If item 27 is marked oth any injury or other traumatic event Fannie Barnhart William H. Baublitz 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Westminster, MD 21157 20b. Plece of Disposition (Name or cemetery, crematory or other place) Barbara W. Kehne Daughter 20e. Method of Disposition 20c. Location - City or Town, Stete 1 XBurial 2 Cremetion 3 Removal from Stete Druid Ridge Cemetery 7/7/99 Pikesville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility 11824 Reisterstown Rd. Eline Funeral HOme Reisterstown, MD 21136 or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, ist only one cause on each line. Approximate Intervel Between Onset end Deeth 23a. Part1. Entre shock, or **Physician** Breast /Medical Immediate Ceuse (Finel diseese or condition resulting in death) Examiner Due to (or as e consequence of) Physician/Medical Examiner requires that the death certificate be executed the attending physician end ched for use es the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events Due to (or es e consequença of) Division of Vital Records, P.O. Box 68760, Due to (or es e consequença of) resulting in deeth) Lest Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Onknown signed by by 20 24b. Were autopsy findings eveilebie prior to completion of cause of deeth? Completed 24a. Wes en eutopsy peed s performed? The law page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 | Nursing Home 5 | Residence 6 Denter (Specify) Huspice 1 Yes 2 No 10 1 Inpatient 2 ER/Outpetient 3 DOA Director: After this in by the funeral d 27. Manner of Deeth 28d. Describe how Injury occurred Certification: Injury et Work? 1 DMaturel 5 Pending investigation death. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) illed in by efter 4 Homicide within 24 hours e To the Funeral C Hospital 1 Cardifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the cause(s) end manner as steled.

2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date and plece, end due to the ceuse(s) end menner steled. edical 29e. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture and title of certifier 0 D43725 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) e of deeth (Item 23e) (Type, Print) 2300 Dylaney Valley Rd. Timunium MD21093 IARIQ MAHMUOD

State



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey Month CARLENE WILLIAMS 05 1999 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number, COUNTY NORTHWEST HOSPITAL BALTIMORE If Under 24 Ars. 18 Date If Under 1 Year 7. Age (In vrs. lest birthdev) Birthplace (State or Foreign Country) 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) 1□M 2□F Months Days Hours Min. 58 Yrs. 217-40-7965 10-24-1940 TABORCITY, NC Usuel Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Tyes 2 No MD BALTIMORE, MARYLAND N/A 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21217 U.S.A. 820 W. NORTH AVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11, Merital Stetus 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Merried 2 Married Specify: BLACK 1 Yes 2 No Specify: 3 Widowed 4 Divorced Yeer or Detes: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) DIETICIAN NURSING HOME 3rd 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) CARLYLE THIMAS JULIA HEMMINGWAY 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) CHARLES WILLIAMS, HUSBAND 820 W. NORTH AVE, BALTO.MD 21217 20b. Plece of Disposition (Name of cemetery, cremetory or other pleca) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Deurial 2 Cremation 3 Removal from State 7-9-99 BALTIMORE, MD 4 Donation 5 Other (Specify) LOUDON PARK 22. Name and Address of Fecility 21. Signature of Funerel Service Licensee WILLIE E. HOWELL HOWELL FUNERAL HOME, 4600 LIBERTY HIGHTS caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, leach line. Approximete Interval Between Onset end Deeth 23e. Part1. Enter the disease, or comshock, or heart feilure. List only Immediete Cause (Final disease or condition resulting in deeth) PREASE DRONARY ARTERY Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest memore manetal Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 D Unknown 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy 2 No 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 Inpatient 2 PER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 27. Manney of Deeth 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete)

physicien and s the buriel-transit Division of Vital Records, P.O. Box 68760. that the death certificate be for use as 1 signed by the s certificate hes b Attending Physician: funeral death. after death Director: 124 hours after the Funeral Direct pletely filled in b 6 Hospital To the Hosp within 24 ho To the Fune completely fi

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/Medical

Examiner

**Funeral** 

**Director** 

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Certification:

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

other

altimore, Maryland 21215-0020

State Registrar

LAURA HARKANA 31. Date filed (Month, Day, Year) 6 1999

540 32. Registrar's Signature

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

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1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end menner as stated.

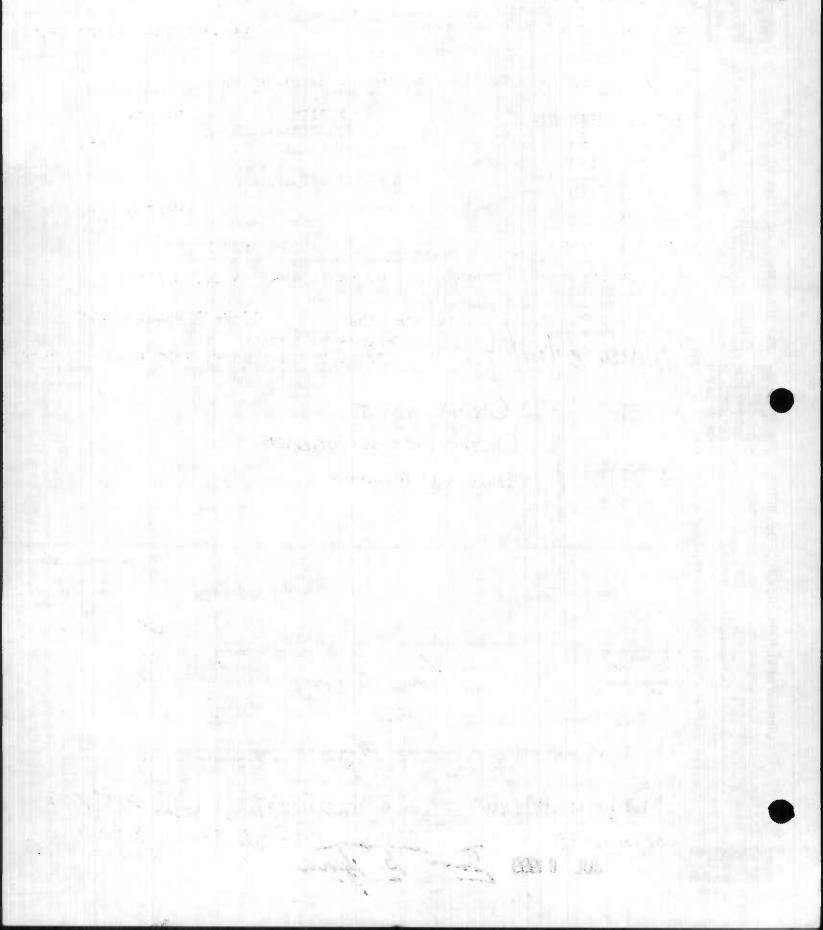
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete end pleca, and due to the cause(s) and menner stated.

29c. License number

WOOTRIAD, RANDALES

29d. Dete signed (Month, Day, Year)

MARYLAND



Piease Type or Print in Black Indeible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene SAMUEL WILLIAMS ITEMS: #23 PART 1, 27 PER MEO G773 7-8-99 WR. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month SAMUEL WILLIAMS 26, 1999 JUNE 0215 AM 4e Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 313 EDGEDALE AVENUE APT.A BALTIMORE CITY NIA 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 1 M 2□ F Days 214-58-7829 Usuel Residence of Decedent 46 Yrs. 10b. County 10c. City, Town or Location 10d. tnside City Limits 12 Yas 2 No 10e. Street and Number 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mohals Hyghene.
met of Health and Mohals Hyghene.
mrt. If Itam 27 is marked other than "retural", or Itama 23a ury or other traumatic avent, the matter Exemptor mass Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) TANITORIAL UNKNOWN 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) WILLIAMS (FIRST NAME - UNKNOWN) JOSEPHINE PARKER 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Place of Disposition (Name of camelary, cremetory or other place)

Dete

| Dete | 20c. Location - City of Town, State MICHAEL WILLIAMS (BROTHER 20e. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from Steta 07-06-99 LANSDOWNE, MARYLANK CEMETERY 4 ☐ Donetjon 5 ☐ Other (Specify) TION 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility H. BROWN JR. FUNERAL HOME JOSEPH FULTON AVE. BALTO, MD. 212 140 N. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. **Physician** tmmediate Cause (Finat disease or condition resulting in death) /Medical ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Lxaminer Due to (or es e consequence of): Examin The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): 288 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by Records, 24b. Were autopsy tindings eveilable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? page 2 should Completed MATTAL 1 Tes 2 No 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Wes case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospitel: 1 | Inpetient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5XX esidence 8 Other (Specify) XX Yes 2 No After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Division 5 Pending investigation or Attanding 1 Neturel death. 1 Yes 2 No 2 Accident the within 24 hours after deat To the Funeral Director: 6 Could not be. 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 ☐ HomicIde To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated.

XX Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier completely (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifier OUS O.C.M.E

State Registrar

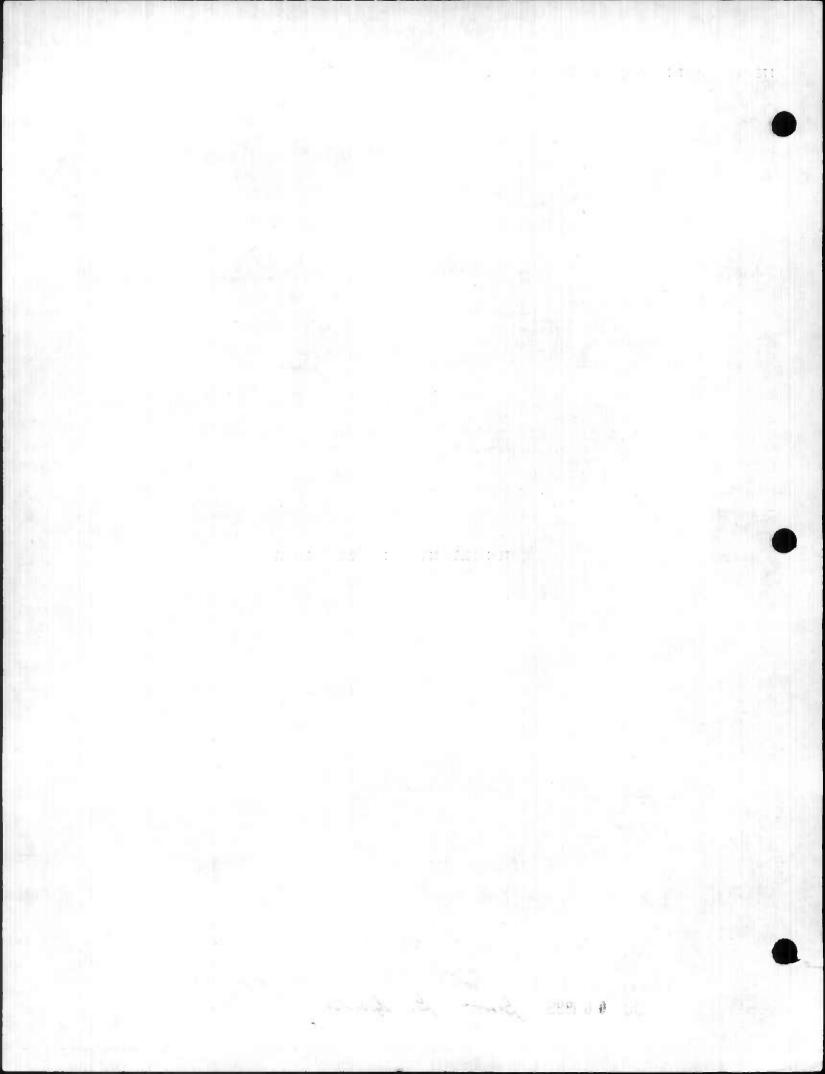
37. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KOWW 111 Penn Street, Baltimore, Maryland 21201

JUNE

26, 1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July 3 1999 Dallas R. Workman 1431 hrs 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore. Md N/A If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth | Montha | Days | Hours | Min. | Jul 21 1930 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stete or Foraign 12M 20F Montha Country) Oh 10 294-26-4090 68 Yrs. Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Parkville 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 7836 Birmingham Avenue 21234 USA 12. Was Decedent Ever in U.S. Armed Forces?

10 / fes 2 10 No \ Q 5 1

If Ves, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14 Race - American Indian Biack, White, etc. 1 ☐ Never-Married 2 ☐ Married 1954
16e. Decedent's Usual Occupation
(Give kind of work done during 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highast grada complated) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N / A Elementary/Secondary (0-12) Dispatcher Arundel Co. 12th 17. Fether'a Name (First, Middla, Last) 18 Mother's Neme (First Middle, Maiden Sumeme) Dallas T. Workman Vivian Rieh1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Debra Shields/daughter 7202 Shadowlawn Ave, Baltimore, Md. 21234 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State 1 ☐ Buriel 2 ☑ Cramation 3 ☐ Ramoval from Steta Greenmount Crematory7/6/99 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
Hartlev Miller Funeral Home 21. Signature of Funeral Service Licensea 7527 Harford Rd 23a. Part 1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, auch as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Balto Md Approximate Interval Between Onset and Death Immediate Cause (Finel Myocardial Infaction 5-10 minutes disaase or condition resulting in death) Dua to (of as a consequence of) Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findinga avellable prior to 24e. Was en eutopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? 28. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide Location (Street and Number or Rural Route Number, City or Town, State)

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Examine Physician/Medicai by Completed 10 Certification:

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Pages 1 and 2 should be filed within 72 hours after death with incert of Health and Mental Hygiene.
Intel filem 27 is marked other than natural; or items 23a or into yor other traumate event, the Medical Education matter

Department of Important: If any Injury or once.

**Physician** /Medical

Examiner

Baltimore, Maryland 21215-0020

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Division of Vital Records. or Attending Physicien: after death. Director: Aft • Funerel ( To the Hosp within 24 ho To the Fune completely fi

> State Registrar

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31. Date filed (Month, Day, Yeer)

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(Check only one)

29a. Certifier

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)
Lise Satter Sell 95/2 Marford Rd, Baltinou, MD 32. Registrar's Signature

6 1999

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A. Sports

1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and piaca, end due to the ceuse(s) end menner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) and menner atated.

29c. License number

D43172

29d. Date aigned (Month, Dey, Year)

28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3 Time of Death Month July 2, 1999 Bryan Wilhelm, Sr. John 9:02AM 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Gilchrist Center Baltimore Towson If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year)
April 28, 1924 5. Social Security Number 6. Sex 1X M 2□ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 75 Yrs. 219-16-8924 Maryland Usual Residence of Decedent 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limita 1 Tyes 2 No Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 307 Deep Dale Drive 21093 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Å No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Mechanical Engineer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Gertrude O'Brien Erenest Wilhelm, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alyce Louise Wilhelm/Wife 307 Deep Dale Drive Timonium, MD 21093 20a. Method of Disposition

1 Burial 2 Commention 3 Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, Stete Baltimore, Washington Crematory July 3, 4 ☐ Donation 5 ☐ Other (Specify) 1999 Laurel, MD 21. Signature of Funera 22. Name end Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Road Timonium, MD 21093 Michael Flagle 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death tmmediate Cause (Final 18 mouth disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Cother (Specify) Hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide

Division of Vital or Attanding within 24 hours efter death.

To the Funeral Director: Af
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/Medical

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Certification:

**Funeral** 

Director

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Baltimore, Maryland 21215-0020

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July 2, 1999 @ 855 Am

Records. the Hospital

> State Registrar

A Riley 31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and the of certifier

32. Registrar's Stgnature

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30. Name end address of person who completed cause of deam (line 28a) (Type, Print)

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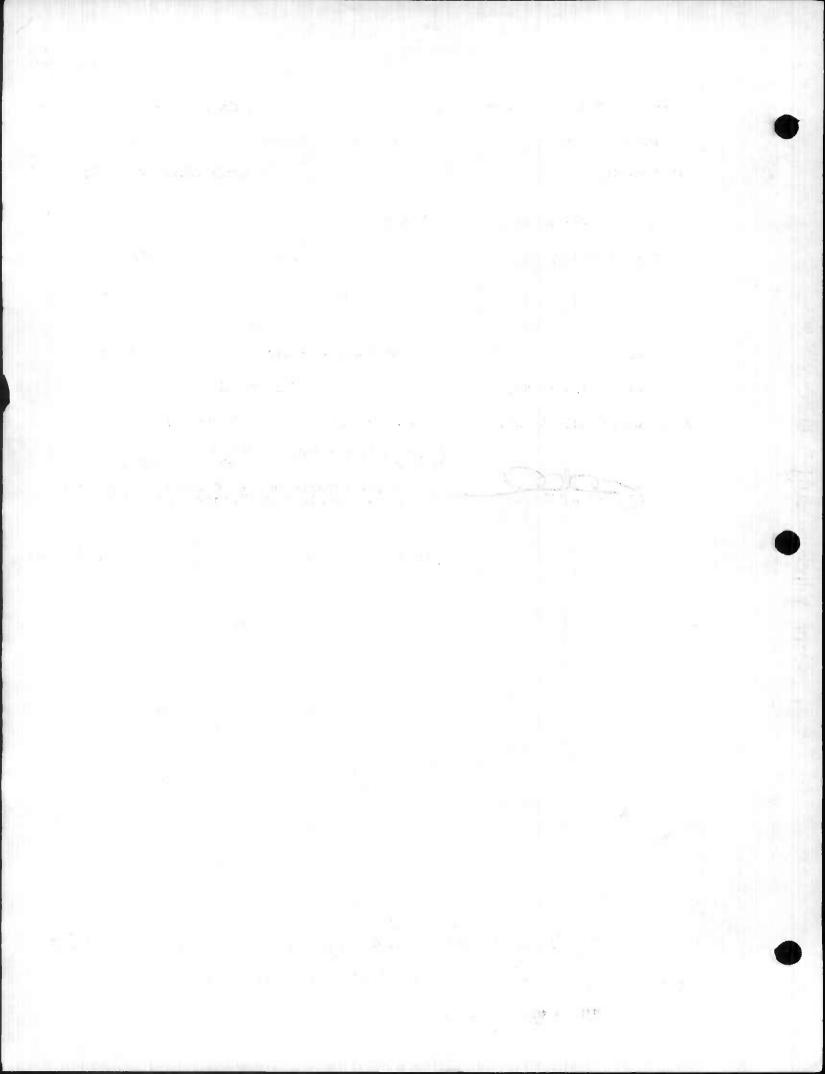
12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29d. Date signed (Month, Day, Year)

N. Charles St. Balto ma 2120x

DHMH 16 Ray 6/95



Registrar **DHMH 16 Rev 6/95** 

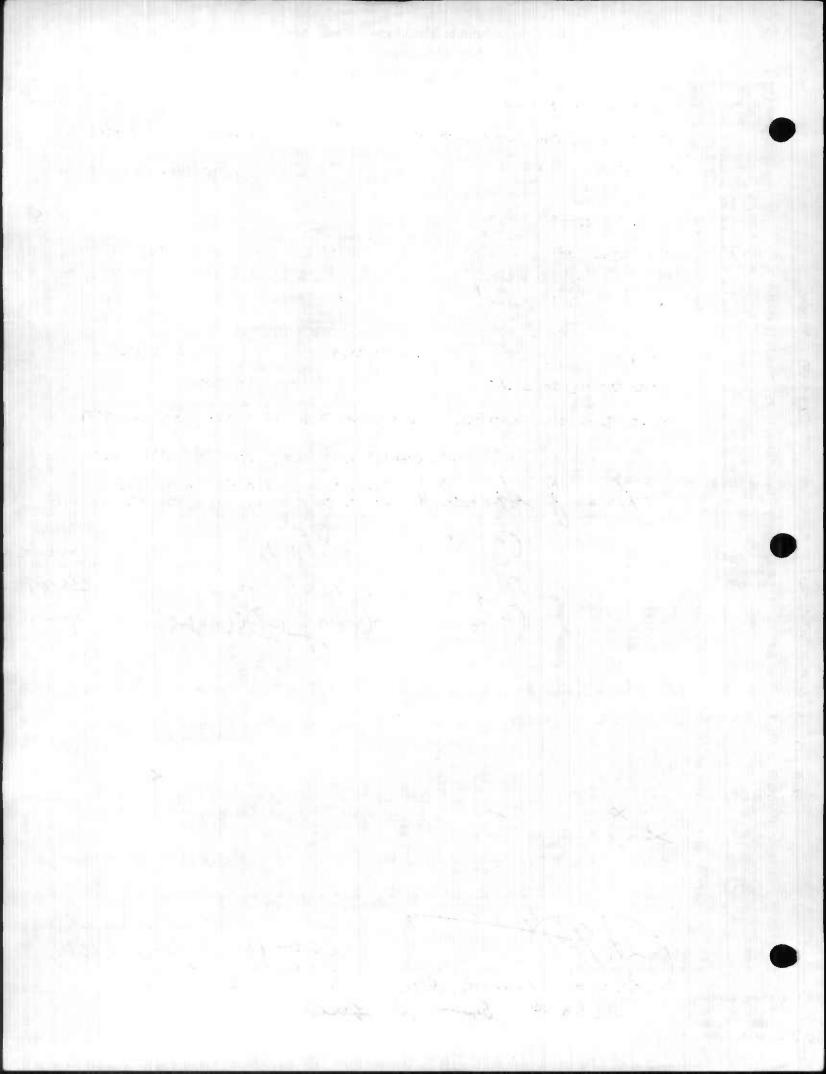
State

Day, Year)

1999

32. Registrar's Signature

215-09-3362



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 20000 June 24 1999 2:00 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 35 Oak Court Annapolis Anne Arundel If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 25, 1934 5. Sociel Security Number 7. Age (In vrs. last birthdev) If Under 1 Year Birthplace (State or Foreign Country) Deys Months Houra 110 M 2□ F 65 215-30-5872 Maryland Usual Residence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Anne Arundel Annapolis Md. 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 35 Oak Court 21401 USA 13. Wea Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Waa Decedent Evar in U,S. Armed Forces? 11 Marital Status 14. Race - American Indian. Black, Whita, etc. 1 ☐ Yes 2 No 1 Nevar Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lineman & installer Telephone Co. 8 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Raymond Aisquith Elizabeth Davis 19a. Informent's Name/Raletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Aisquith / son 1723 Fairhill Dr. Edgewater, MD 21037 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removel from Stete 4 Donetion 5 Dother (Specify) 6-26-99 Hillcrest Cemetery Annapolis, Md. 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service Licenses 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximata Interval Between Onset and Death Immediate Cause (Final diseese or condition rasulting in deeth) Sequentially list conditiona, if any, leading to immadiate cause. Entar Underlying Cause (Diseasa or injury that initiated events resulting In death) Lest ancreas 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 ANO 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 2 No 1 ☐ Yas 2 ☐ No 25. Wes casa referred to medical axaminar? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) No 1 ☐ Inpetient 2 ☐ ER/Outpetient 3□ DOA 28d. Describe how injury occurred

**Physician** /Medical Examiner

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24 hours after deat Funeral Director:

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Medical

**Physician** 

/Medical

Examiner

**Funeral** 

Director

iral", or Nerra 23a or 28a-f show Examiner must be notified at

"natural", or Name 23a

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permit. Pages 1 and 2 should be filed within 2 Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "na any Injury or other traumatic even."

Baltimore, Maryland 21215-0020

Examiner physician a signed by the Certification: To funeral

The law requires that the death certificate be axecuted

Box 68760.

P.O.

Records,

Division of Vital or Attending Physician: Physician/Medical p Completed Be

1 Yes 27. Manner of Deak 5 Pending Neturel

2 Accident 6 Could not be 3 ☐ Suicide 4 Homicida

28a. Data of Injury (Month, Dey Year) Investigation

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of 28c. fnjury at Work?

1 □ Yes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier

29a. Certifier

(Check only one)

allen WI 29c. License number

29d. Dete signed (Month, Day, Year)

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) Road 900

31. Date filed (Month, Dey, Year) JUN 2 5 1999

32. Registrar's Signeture

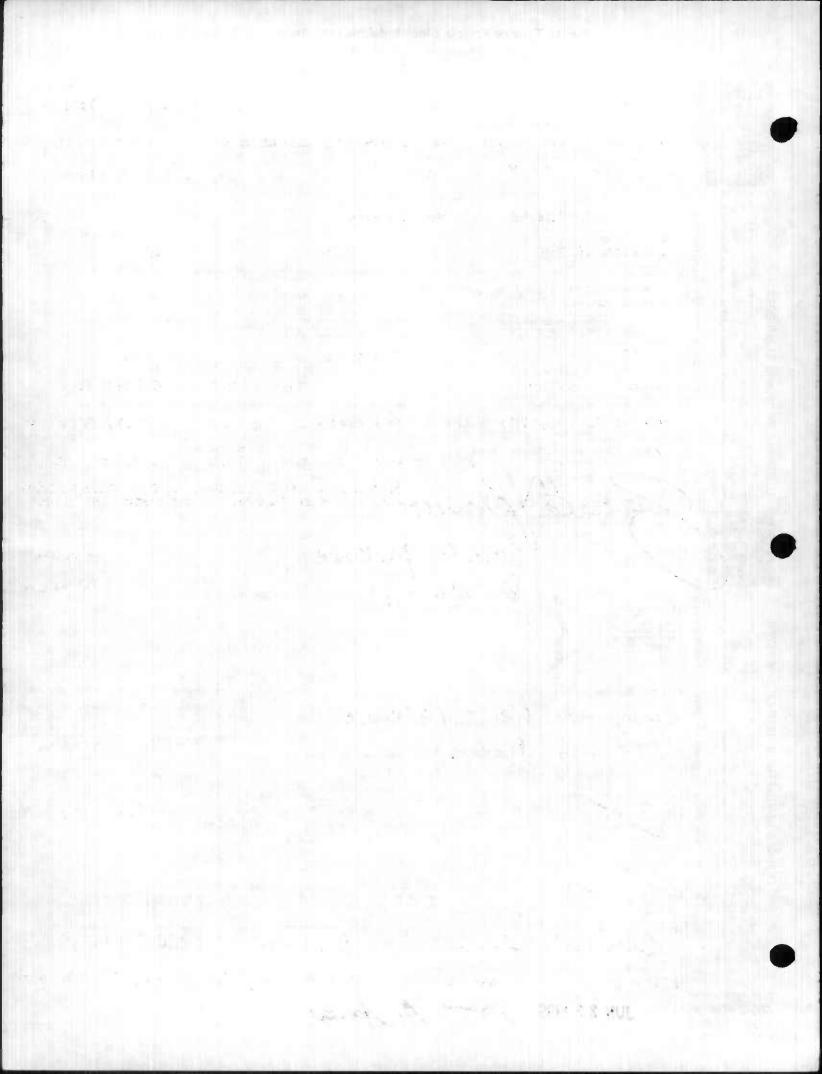
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## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9

			Ce	rtificate of	Death		Reg. No.			
Physician /Medical	Decedent's Name (First, Middle, L. Eugenia		nold			2. Date of D Month June	Day	Year 7:00 am		
Examiner Funeral		e Chesapea	yrs. last birthday)	idence		Min. (Month, I	Anne lirth Dey, Year)	Arundel  9. Birthplace (State or Foreign Country)		
er death with the Maryland theme 23s or 28s-f show one must be notified at tuneral Director	Usual Residence of Decedent		81 Trs.	1		Mar	8, 1918	Maryland		
	MD 10b. County Anne Ar		ty, Town or Location everna Park				10d. Inside City Limits 1 ☐ Yes 2 ☑ No			
	10e. Street and Number 350 Preswick Wa		10f. Zlp Code 21146			10g. Citizen of What Country? USA				
	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced		S. 13. Was Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexican, Puerto I			pecify Yes or No- Rican, etc.)  14. Race - American In- Black, White, etc.  Specify: White				
od within 72 hours al spans, restural, or t, the Medical Exam Completed by I	15. Decedent's Elementary/Secondary (0-12)	(Give	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)			16b. Kind of Business/Industry				
Be dother Be	17. Father's Neme (First, Middle, Las Dennis J. Byr			omemaker	18. Mother's Neme (First, Middle, Mary Catherin			e)		
d Men d Men marks marks	19a. Informant's Name/Relationship		10h Meili	no Address (Street		or Rural Route Nun				
C = 04 P	Denise S. Pog  20a. Method of Disposition	gi/Daughte:	r 35	0 Presw	ick W	Vay Sev	erna Pa:	rk, MD 21146 City or Town, State		
diffilliore, mil. Pages 1 a partment of Hau portant: If Nem y injury or othe	15 Burial 2 Cremation 3 Removal from Cemetery, crematory or other place) 4 Donation 5 Other (Specify)  Parkwood Cemetery 1999 Baltimore, MD									
Department	21. Signature of Figure al Service Lice	X KRR	mod	2. Name and Addre arranco & 95 Gov. R	Sons,	P.A. Sev Hwy. Se	verna Parl	k Funeral Home rk, MD 21146		
Physician	Part 1 Enter the disease, or cor shock of heert feilure. List only	nplications that caused the conscause on each line.	death on the	ter the mode of dyin	ng, such as co	erdiac or respiratory	errest,	Approximate Interval Between Onset and Death		
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	· Kenat	ja	ilure	)			2 years		
HILLS &	Due to (or es a/consequence of):									
A 00 00, entitionable be exacute fing physician and as as the burishment Medical Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that influsted events resulting in death) Last  Due to (or as e consequence of):  Due to (or es a consequence of):									
death or differ us	Part It. Other significant conditions	contributing to death but no	t resulting in the u	inderfylna ceuse an	ven in Part I.	23b. D	d tobacco usa cor	ptribute to the cause of death?		
	Congstire heart Pailure					11	1 Yes 2 No 3 Probably 4			
Of Vital Records, Physician: The law requires the this certificate has been agree and director, page 2 should be done in To Be Completed by	coronary					es en autopsy formed?	24b. Were autopsy findings aveileble prior to completion of ceuse of death?			
The law The law page 2	-					1[	Yes 2 No	1 ☐ Yes 2 ☐ No		
atificate stor. pa										
Physician: this certific ral director. To Be	1□Yes 2⊞No	Hospital: 1 Inpatient	2 ER/Outpetie	NI 3LI DOA		sing Home 5 Re		er (Specify) Hopice How		
Attending P or death or death by the funeri diffication:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	of 28c. Injury at Work?  M 1 Yes 2 No			red					
w take t	3 Suicide 4 Hamidde  6 Could not be determined  28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)				office 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Hospi M hou Funer cely fill	29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated.  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated.  2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated.  2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated.									
To the within 7 To the comple	29b. Signature and title of certifier	19b. Signature and title of certifier  29c. License number  29d. Date signed (M  D 3 1 9 9 8  O 6 - 2					21-95			
	30. Neme and address of person who	completed cause of deeth			Ridg	ely Are	Anna	polis MD 21401		
State Registrar	31. Date filed (Month, Day, Year)  JUN 2 3 199	9 32 Aegistrar's S	Signeture 6.	Spark	/					



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month 21, 8:03 pm Walter June 1999 William 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8335 Woodland Road Pasadena If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 1√2 M 2□ F Months Days 219-32-8234 62 Apr 12,1937 Maryland Usual Residence of Decedent 10a State 10c. City. Town or Location 10b. County 10d Inside City Limits Anne Arundel 1 ☐ Yes 2€ No Pasadena 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 8335 Woodland Road 21122 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2√ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Real Estate/ College (1-4or 5+) Eiementary/Secondary (0-12) Insurance Sole Proprietor 18. Mother's Name (First, Middle, Malden Sumame) 17. Father's Name (First, Middle, Last) Fred Mary Virginia Lancaster Boswell 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8335 Woodland Road, Pasadena, MD 21122 Helen Basil Boswell/wife 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition June24 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removei from State Baltimore, MD Metro Crematory 1999 4 ☐ Donation 5 ☐ Other (Specify) 21. Sanature of Funerai Servica Licenses 22. Name and Address of Fecility Barranco & Sons, P.A. Severna Park F.H. 495 Gov. Ritchie Hwy., Severna Park, MD 21146
Approximate Interval Between Onset and Death ter the disease, or complication heert failure. List only one Cause (Final disease or condition Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting In death) Last Due to (or as a consequenca of): Due to (or as a consequence of) Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Was an autopsy 1 Yes 2 HM 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Amesidenca 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. injury et Work? 28d. Describe how Injury occurred 28b. Time of 5 Pending investigation 1 Maturel 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide

됥 Division of Vital Records, P.O. Box 68760, 8 2 Ĕ law. certificate Pit. Affier Athending death or A Funeral D hours To the Ho Within 24 I To the Fur

physician a 8 the burial 949 8 for use as signed d be det **page 2** 

**Physician** 

/Medical

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State Registrar

31. Date filed (Month, Day, Year) JUN 2 3 1999

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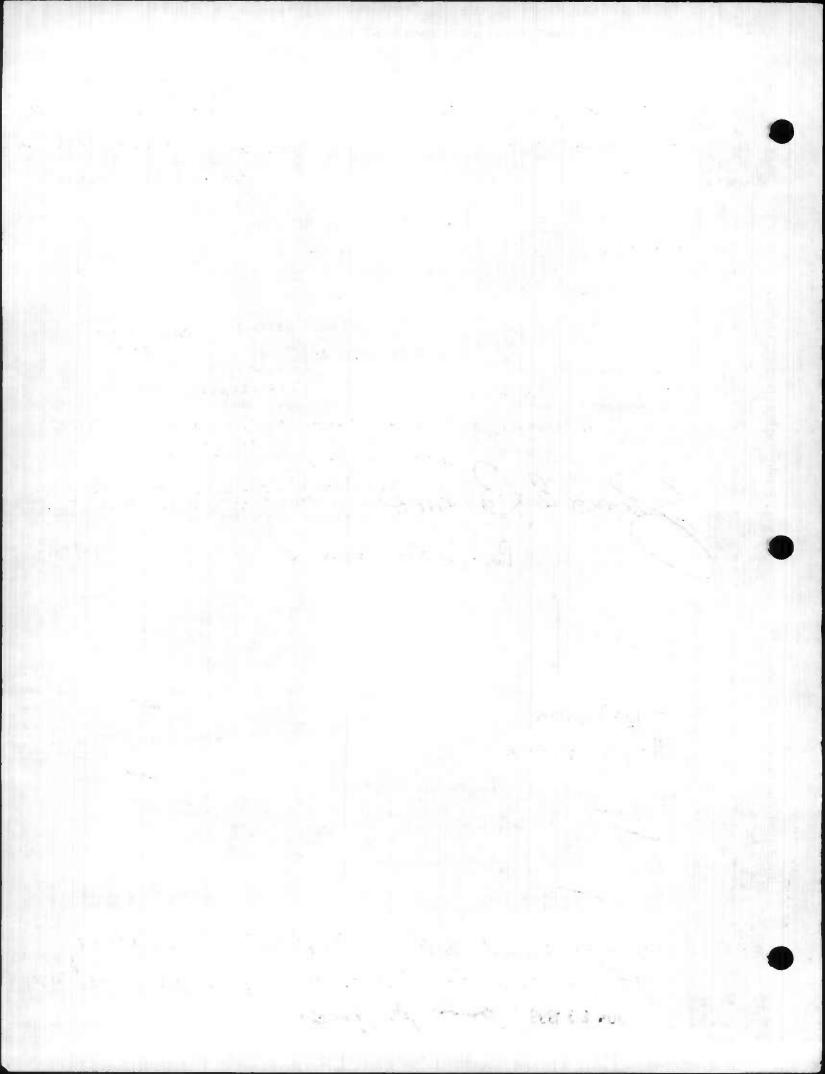
of deeth (item 23a) (Type, Print) 205 32. Registrer's Signature

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

21401

**DHMH 16 Rev 6/95** 



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** ROBERT A. BADEN 18 1999 JUNE 1750 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 15M 20 F Director 216-18-5336 JAN. 5 1922 MARYLAND Usual Residence of Decedent the Maryland 10a State 10c. City, Town or Location 10b. County r than "natural", or flems 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits No Yes 2□No Director MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1032 HARBOR DRIVE 21403 US 12. Was Decedent Ever in U,S. Armed Forces?

1X2 Yes 2 No 1f Yes, Give Year or Dates: 1944-46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours effer Hygiene. other than "natural", or he 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 312 Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. EXPERIMENTAL permit. Pages 1 and 2 should be filled with Department of Health and Mental Hyglene Important: if Item 27 is marked other that eny Injury or other traumatic event, that pages. STATION 17. Father's Name (First, Middle, Last) LABORER 18. Mother's Name (First, Middle, Maiden Surname) 8 EUGENE BADEN LAUREL BETTERS 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 1384 GALLOWAY RD. ODENTON, MD. 21113 ADELL GALLOWAY (DAUGHTER) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) ANNAPOLIS MEM. GARDENS 6/23/99 ANNAPOLIS, MD. 21. Signeture of Funeral Service Licensea 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Applications that caused the death. Approximate Interval Between Onset and Death **Physician** Cardcae /Medical fmmediate Cause (Final disease or condition resulting in death) Cellest 1 de un ? d Examiner Due to (or as a consequence of): Examine COPO 415 that the death certificate be axecuted physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Due to (or as a consequence of): Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 No 3 Probably 4 Unknown signed b by The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? Be 26. Piace of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 35-DOA this 27 Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 A Netural Attending 5 Pending investigation n 24 hours after death.

• Funeral Director: Aftioietaly filled in by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 5 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 130718

State Registrar

2007 Midael 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jackery Les

Acceptes, MD 21401

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	,	AMEND#8 PER F.H. G774 8-	State of Maryland / 1 17-99 J.A.	Certificate of			i. No.	21198			
	Physician /Medical	Decedent's Neme (First, Middla, Last)     MASZIE BROWN				2. Dete of Deeth Month UNE 16	Dey Ye	3. Time of Deeth 8:10 pm			
	Examiner  Funeral Director	4e Facility Neme (If not Institution, give s  ANNE ARUNDEL MEI  5. Sociel Security Number  212-26-8468	DICAL CENTER	A	NNAPOLIS  If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear)	Deeth			
	5-0020 72 hours after death with the Meryland natural; or Items 23s or 28s-f show feel Exercises must be notified at sted by Funeral Director	Usuel Residence of Decedent  10a. Stete 10b. County	10c. City, Tow	vn or Location				10d. Inside City Limits			
		MARYLAND ANNE AI	RUNDEL ARNOL	D 10f. Zip Code		100	g. Citizen of Wha	1  Yes 2 No it Country?			
	th with						US				
020	urs after death vil., or thems 23.	11. Merital Status  1 Never Merried 2 Merried  3 Widowed 4 Divorced	13. Wes Decedent of H If Yes, specify Cube 1 ☐ Yes 2 ☐ No	lispenic Origin? (Spe en, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Rece - American Indien, Bieck, White, etc.  SpecifiBLACK					
21215-0020	ed within 72 hours ygiena. er than "natural", ft, tre Med sal Ex. Completed by										
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Maryland	d 2 should be the end Mental I is marked or traumatic sve	LAWRENCE GRIFFIN  19a. Informent's Neme/Reletionship (Type, Print)  19b. Mailling Address (Street end Number or Rural Routa Number)						per, City or Town, State, Zip Coda)			
	f Health e Item 27 is other trac			1 E. JOYCE of Disposition (Nama of	LANE AR						
Baltimore,	S T T	20a. Method of Disposition  CDSurial 2 Cremation 3 R 4 Donetion 5 Other (Specify)	camete	ALVARY CHU	RCH CEME			y or Town, State NOLD, MD.			
Balt	permit. Pag Department Important: It any injury o	21. Signeture of Funeral Service Licansee  22. Name and Address of Fecility  WM. REESE & SONS MORTUARY, P.A.									
	Physician (Modical	23a. Pert1. Enter the disease, or comblishock, or heart failure. List only on		not enter the mode of dyir	ng, such es cardiac or	r respiretory arres	it,	Approximate Interval Between Onset and Death			
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Box 68760,	= - 10	Ceuse (Disease or injury that initiated events resulting in deeth) Lest	Due to (or es a								
	et the deeth certification of the attending etached for use as Physiclan/Me	Pert li. Other significant conditions con	ributing to death but not resulting	in the underlying ceuse giv	ven in Pert I.	23b. Did tob	acco uae contri	bute to the cause of death?			
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Records,	aw requisits been 2 should						eutopsy ed?	24b. Were autopsy findings available prior to completion of cause of death?			
	The law sate has page 2					1 □ Yes	28No	1 ☐ Yes 2 ☐ No			
Vital	Physician: The this certificate ral director, page To Be Co	25. Wes case referred to medical examiner?	ospitel: 1 Inpatient 2 ER/O	outpatient 3 DOA Oth	26. Plece of Deeth	(Check only ona)		(Specify)			
ou of	Attending Physic death.  ector: Atter this by the funeral diffication: To	27. Menner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of injury 28b.				28d. Describe how injury occurred				
Division	Patric F	a D C could not be				281. Location (Street and Number or Rural Route Number, City or Town, Stata)					
	To the Hospital within 24 hours a To the Funeral I completely filled	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner es stated.  2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end manner stated.									
	To the comple	29b. Signety a end title of certifier & Lucut &	Jelouil, a	40. 29c. Licens	19838	296	d. Date signed (	Month, Day, Year)			
		30. Name and address of person who co	mpleted cause of deeth (Item 23e)	(Type, Print) Best	gate Rd.	Auno	ipolis,	Mid. 21401			
	State Registrar	31. Dete filed (Month, Day, Year) JUN 23 1999	32/Registrar's Signeture	4 /							

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

		Examin Funeral Director
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland	Department or results and Neutral Aggents. Importment of results and Neutral Aggents. Importment it flam 27 is marked other than "neutural", or flems 23e or 28e-f show any injury or other traumetic event, the Medical Examiner must be notified at SDSs.
•	Ph: /\\ Ex	ysician Medical aminer
Records, P.O. Box 68760,	he law requires that the death certificate be executed	e has been signed by the attending physician and sge 2 should be detached for use as the burial-transit

ULUL I	Decedent's Neme (First, Mi	ridia ( ast)		Cer	tificate	of	Death	2. Dete of De	Reg. No.	0 6	3. Time of Deeth
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/Medical	Abbie 4a Facility Neme (If not institu	VIRGI					Banks 4b. City, Town, or L	June 1		ty of Death	2:50 PM
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Funeral Director	214-10-6634 Usual Residence of Decedent	1□M 2፟ØF	86	Yrs.	Months	Days	Hours Min.	B. Dete of Bi (Month, D OCT 7,	1912	MARY	place (State or Foreign http:// LAND
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or 28e-f a be notified	10e. Street and Number	011200	1 02	LUBURI	10f. Zip C	ode			10g. Citizen of	What Cour	ntry?
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Physician /Medical Examiner	23a. Pert1. Enter the disease shock, or heart failure. I Immediate Cause (Finet disease or condition resulting in death)	a. ENC	Due to (or	ge C	Unav	VIC	ab Sor	Resture	, Se 49 D	a	Intervel Between Onset end Death
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tificate be executed as the burial-transit	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or	as a consequal	uence of):	-					
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the death certified by the attending standing st	Pert II. Other significant cond	Itions contributing to deat	th but not resul	iting in the un	derlying car	ig esu	ven in Part I.		Yea 2 No		o the causa of death?
or Attending Physicien: The law requires that the death certain after death certain the death certain the free that the free that the first of the first or, page 2 should be detached for use etification: To Be Completed by Physician/Nertification: To Be Completed by Physician/Nertification:		Marie I							s en eutopsy ormed?	ev cc	fere autopsy tindings vailable prior to empletion of cause deeth?
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th. After this funeral	27. Menner of Death 1 2Naturat 5 Pen 2 Accident inve	28a. Date of		28b. Time of Injury		c. Inju			how injury occi		
To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.  Medical Certification: To Be Comp	3 ☐ Suicide 6 ☐ Cou	ld not be ormined 28e. Place of building	I Injury - At hor , etc. (Specify)	me, farm, stre	et, factory,	office	×		(Street and Nun own, State)	nber or Run	al Route Number,
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State Registrar	31. Dete filed (Month, Day, Ye JUN 1	8 1999 32. Reg	ighrar's Signatu	ure &	de	non.	61				

DHMH 16 Rav 6/95

By many TENST MAL

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 22° **Physician** 1999 Roland William DeWolf June 11:25 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1123 Lake Heron Dr. Apt. B-3 Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 XM 2 F 70 Yrs. 201-22-3045 17,1929 Director Virginia Usuat Residence of Decedent with the Marylenc 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-4 show other traumetic avent, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Anne Arundel Directo Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1123 Lake Heron Dr. Apt. B-3 21403 USA deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours aftar of Department of Haalth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any Injury or other traumatic avent, the Woddenl Exemp Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: by 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Etementary/Secondary (0-12) Engineer Civil Engineering 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Pearl Smith R. William DeWolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne R. DeWolf / wife 1123 Lake Heron Dr. Annapolis, MD 21403 Apt. B-3 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-24-99 Brentwood, MD Ft. Lincoln Crematory 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 21. Signature of Funeral Service Licensi 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** rostatic CANCER Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner attending physician and for use as the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. detached signed by to 1 Yes 2 No 3 Probably 4 € Unknown þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? pege 2 has 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was cese referred to medicel examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural Attending 5 Pending investigation s eftar death. 1 TYes 2 TNo 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide hours Hospital 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of partition

**JUN 2 5 1999** 



29c. License number 019838

29d. Date signed (Month, Day, Year)

To the within 2

JUN 25 1999 James D. March



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** 22 Edwena Kathryn Dudley June 7:32 PM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) March 2, 1924 Birthplace (Stata or Foreign Country)
 New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2♥F 75 Yrs. 220-12-5853 Director Usual Rasidence of Decedent the Manyland 10a Stata 10b County 10c. City, Town or Location 10d Inside City Limits r than "natural", or items 23s or 26s-f show the Madical Examinar must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Gambrills 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 3112 Gosheff Lane 21054 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 □ ¼as 2 □ No If Yes, Giva Year or Datas: ₩₩ II Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 11 Marital Status 14. Race - American Indian, Black, Whita, atc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White ò 31 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Discount Store 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be Charles B. Oliver Elizabeth Edwards 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Charles R. Dudley / Son 3112 Gosheff Lane Gambrills, MD. 21054 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from Stata Susquehanna Mem. Gardens 6-26-99 4 Donation 5 Othar (Specify) York, PA. 22. Name and Address of Facility John M. Taylor Funeral Home, Inc 21. Signature of Funaral Service Ligar 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final a Basal Ganglian

Due to (or as a consequence of): diseasa or condition rasulting in death) Examiner Examiner ere brovascular physician and s the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of) Box 68760. Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. Rhaboomyalusis 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? 1 ☐ Yas an No 1 Yas 2 No Division of Vital or Attending Physician: 25. Was casa refarred to medical examinar?

1 ☐ Yas 2 ☑ No Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA edical Certification: To this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending n 24 hours after death.

The Funeral Director: After pletely filled in by the fun 1 Yas 2 No invastigation 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to the cause(s) and mannar as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and mannar stated. 29a. Certifier To the Hosp within 24 hos To the Fune completely fi (Check only one) and the of certifier 29c. Licensa number 29d. Data signed (Month, Day, Year) D47518 6-23-99 MYSIGA Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) Anc Franklin Cathedral ST ANNAPOLIS, MO 21401 Theresa Buck, mo 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State JUN 2 4 1999 Registrar

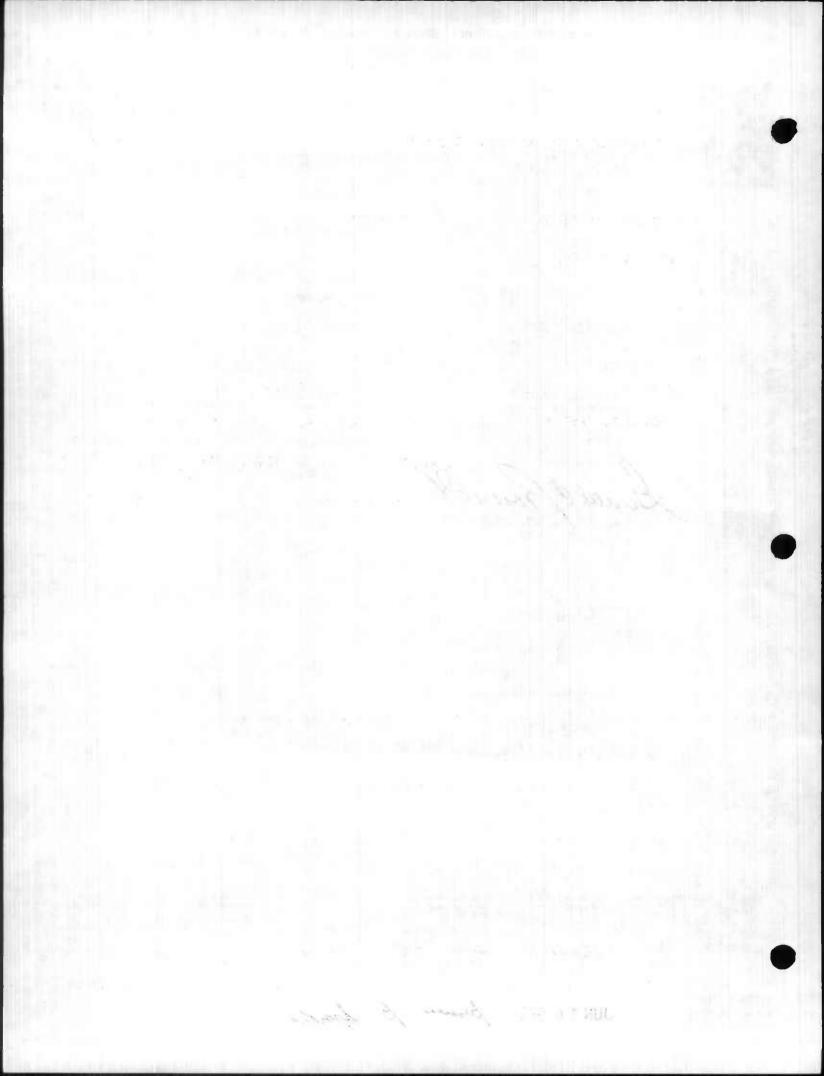
DHMH 16 Rev 6/95

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	Decedent's Name (First, Middle, Last)	Ceruno	cate of	Death	2. Data of Dea		Year	3. Time of Death
ian ical	SHELDON B.  4e Feclify Neme (If not institution, give street and number)	I	DAWSON	lb. City, Town, or I	JUNE	Dey 15, 194 4c. County	49	0107
ner	PENINSULA REGIONAL MEDICAL C	ENTER		SALIS	BURY	WI	COMI	CO
	5. Social Security Number 6. Sex 1 M 2□ F 7. Age (In yrs. 83		Inder 1 Year onths Deys	If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day JUNE 27	, Year)	9. Birthp Cour MAR	olece (Stete or Forei ntry) YLAND
	Usuel Rasidanca of Decedent	. T					1.	
Director		ity, Town or Location						0d. Inside City Limi Yas 2□N
-	MARYLAND   WICOMICO   10e. Street and Number	SALISBU	f. Zip Code			log. Citizen of V	What Cour	+
	1307 TANEY AVE.		21801			U.S.A.		M. y .
	11 Marital Status 12. Was Decedant Ever in U	J,S. 13. Was D	Decedent of H	lispenic Origin? (S	pecify Yes or No-	14. Rac	e - Amario	can Indien,
	1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Giva Yaar or Datas:		as 2X No	Specify:	o Hican, atc.)	Specify	k, White, WH	eic. ITE
	15. Decedent's Education (Specify only highest grede completed)	16e. Decedent's	Usuel Occup	etion	kina	16b. Kind of Bu	ısinass/in	dustry
	Elemantary/Secondery (0-12) College (1-4or 5+)			during most of wor	King .	D		
	1.2 8	EDUCATO	OR	19 Mother's Nam	ne (First, Middle,	PUBLIC	_	OOLS
manufacture of the	SEVERN DAWSON			SADIE	HAYMA		(6)	
	19a. Informent's Name/Ralationship (Type, Print)			end Number or Ru				Code)
	PAULINE P. DAWSON	1307 TA		VE. SAL	ISBURY, N			21-1-
	1 N Burlal 2 □ Cremetion 3 □ Removel from State	Place of Disposition cematary, cremetory	y or other plea		Data	20c. Location -		
		RINGHILL				HEBRON 705 E. N		
	21. Signatured Funeral Service Licenses	22. Nan	ne end Addre	ss of Facility				
	Pert1. Enter the disease, of complications that caused the dee shock, or heart failure. List only one cause on each line.			ERAL HOMI			JRY, M	Approximate
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cousa (Disease of Injury	Cling dea yer or es e consequence Les es deu Les or as a consequence or as e consequence	a of):  of):					I weeks
Icla	Part II. Other significant conditions contributing to death but not re-	sulting In the underly	ing cause giv	en in Pert I	23b. Did t	obacco use co	ntribute t	o the cause of dea
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Be	25. Wes case referred to medical examiner?				ath (Check only o	ne)		
10		ER/Outpatient 3		4 LI Nursing F	loma 5 ☐ Resid			(y)
HION	27. Menner of Death  1 Deatural 5 Pending (Month, Dey Year)  2 Accidant Investigation	28b. Time of Injury	28c. Injur Wor	yet k? Yes 2 □ No	28d. Describe h	ow injury occur	red	
er mino	3 Sulcida 6 Could not be datarminad 28e. Placa of Injury - At houlding, atc. (Space	nome, ferm, street, fe	ectory, office		28f. Location (S City or Tow	Street and Numb n, Stete)	er or Run	al Routa Number,
edical Certification:	29e. Certifier (Check only one)  1 Certifying Physician: To the best of my kn. 2 Madicat Examinar: On the basis of examinar and manner stated.							
N e	29b. Signeture and title of certifier	BEV-	29c. Licens	e number		29d. Date signe	d (Month,	Dey, Year)
-	Vand & (1 letter	MIS	000	5 1969		6-1	5-99	L T
5	2000 11.					13/		
8	30. Name and addrass of person who completed cause of death (Italian Tames 4. CLIFFORD M.O 106)				SALISBE	10 41		1/54/

DHMH 16 Rev 6/95

SHELDON DAWSON



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. AMEND# 26 6/25/99 CMH AACO HEALTH DEPT CASES AND ACCOUNTY OF THE ALTH DEPT CASES AND ACCOUNTY OF THE ACCOUNTY OF T 'Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** M. Ronald Epstein June 22 1999 6:10 AM /Medical 4e Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 780 Fairview Ave. Annapolis Anne Arundel Apt. A If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) B. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** Days 1 XM 2 F Director 578-40-8866 67 March 20,1932 Wash., D.C. Usual Residence of Decedent with the Maryland 10a Stata 10b. County 10c. City, Town or Location "natural", or items 23s or 28s-f show 10d. Inside City Limits W Yas 2 No Director MO Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 796-D Fairview Ave, permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural" or incorporate or the traumatic avairable. 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. 11. Meritel Stetus Black, White, atc. Armed Forces:
1 1 Yes 2 No
If Yes, Give
Year or Dates: 1953-56 1 ☐ Never Merried 2 ☐ Merried 1□ Yes 2□ No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elamentery/Secondery (0-12) College (1-4or 5+) Electrical Contractor Elec. Supply 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Abraham Epstein Ida Kelrick 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Jane Duvall / wife 780-A Fairview Ave. Annapolis, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Steta 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Metropolitan Crematory 6-24-99 Alexandria, VA. 22. Name and Address of Fecility John M. Taylor Funeral Home, Inc. 21. Signature of Funerel Service Licenses 147 Duke of Gloucester St. Annapolis, MD 21401 M 23e. Part 1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Betwe Onsat and Death **Physician** Immediate Cause (Fine! disease or condition resulting in deeth) /Medical nhacianal Pressure Examiner Physician/Medical Examiner attending physician end for use es the burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if eny, laading to immediate cause. Enter Underlying Causa (Disease or Injury Due to (or as a conseq Box 68760, thet initieted events rasulting in death) Last Due to (or #5 e consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? Completed page 2 s 1 Yes 2 No 1 ☐ Yas 2 ☐ No Physician: Be 25. Wes casa referred to medical 26. Place of Death (Check only opa) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 9 Thesidence 6 Wother (Specific STERCE 1 Yes 2 No Certification: To After this 27. Menner of Deeth 28d. Describe how Injury occurred 5 Pending investigation 1 Netural after death.
I Director: After the full of 1 Yes 2 No 2 Accidant

of Vital Division or Attending Hospital

> State Registrar

completely filled in by

edicai

within 24 hours a To the Funeral L

31. Data filed (Month, Day, Year) JUN 2 5 1999

6 Could not be determined

M.D.

3 Suicida

29e. Certifier (Check only one)

4 Homlcide

29b. Signeture and title of certifier

Curtis Harris,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 Ridgely Ave 32. Fjegistrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Annapolis, MD

Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to tha causa(s) and manner as stated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to tha cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

21401

29d. Date signed (Month, Day, Year)

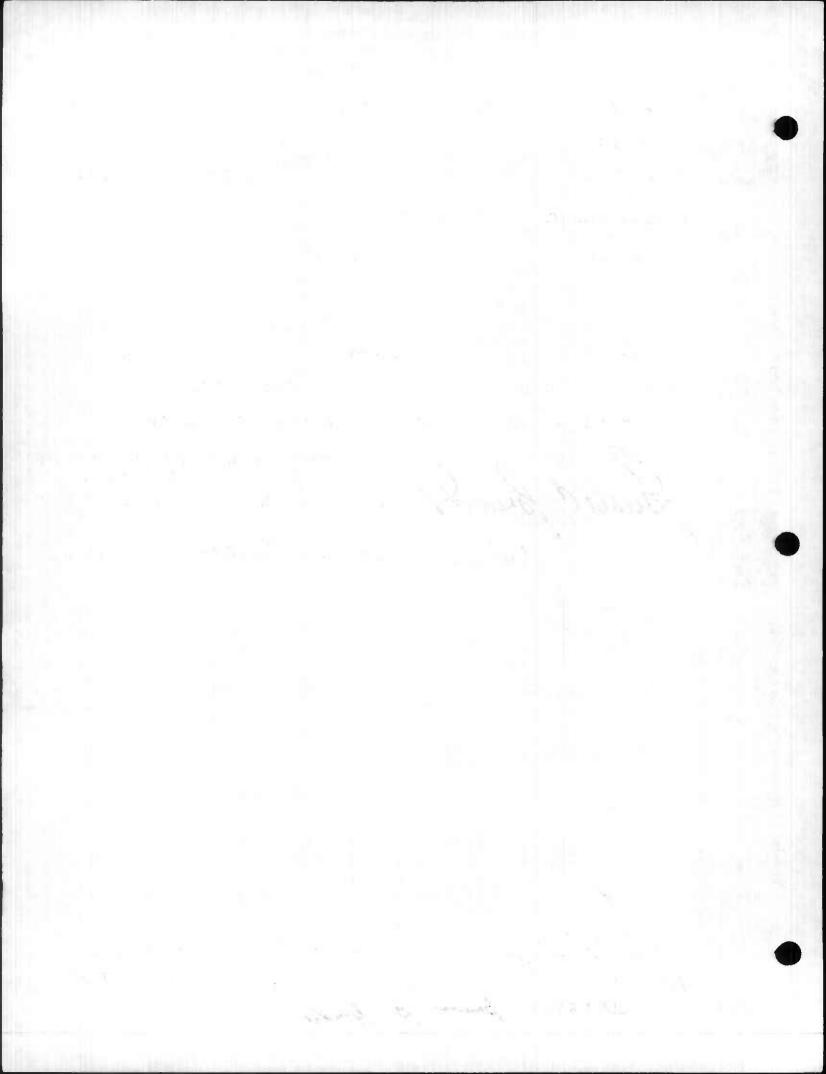
## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 1. Decedant's Name (First, Middla, Last) Month **Physician** ENNIS 1999 10:45 PM KATHERINE MAE TUBBS JUNE 14 /Medical 4b. City, Town, or Location of Death 4a. Facility Nema (If not institution, giva streat and number) 4c. County of Death Examiner WILLARDS WICOMICO 7283 MAIN ST. If Undar 1 Year If Undar 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🗓 F Yrs Director 213-22-4970 72 MAY 25,1927 MARYLAND Usual Rasidance of Dacedani the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Yes 2 No Director MARYLAND WICOMICO WILLARDS 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? With 21874 7283 MAIN ST. U.S.A. death Funeral 12. Was Dacedenf Ever in U,S. Armed Forcas? Was Decedant of Hispanic Orlgin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Meritel Stetus 14. Race - American Indian, Black. Whita, atc. 2 should be filed within 72 hours efter and Mental Hygiene. is marked other than "natural", or ite 1 ☐ Yas 2 X No If Yas, Giva 1 Navar Married 2 Married altimore. Maryland 21215-0020 1 ☐ Yas 2X No þ π yas, Giva Yeer or Detas: Specify: 3 ₩ Widowed 4 Divorced WHITE 15. Decedant's Education (Specify only highast grada completed) 16e. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) BANK 12 BOOKKEEPER 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be EDWIN TUBBS HELEN E. DENNIS 2 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straet and Number or Rural Route Number, City or Town, Steta, Zip Coda) permit. Pages 1 and 2 sh Department of Heelth and Important: If Itam 27 is m any Injury or other traum MARGARET WHITE - DAUGHTER 9280 GREEN BRANCH RD. WILLARDS, MD 20b. Placa of Disposition (Nema of cemetery, cramatory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stata Dete Cremetion 3 Ramoval from Stete 1 Durial 6/18/99 PITTSVILLE, MARYLAND 4 Donation 5 Other (Spacify) PITTSVILLE CEMETERY 705 E. MAIN ST. 22. Name end Addrass of Facility BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 ations that caused the dailin. Do not enter the mode of dying, such as cerdiec or respiratory arrest, a ceuse on each line. Approximate Intervel Between Onsat end Deeth Ph sician of GALL Bladder Immediata Cause (Final disaasa or condition rasulting in death) /Medical 12 mo Examiner Due to (or as a consequence of) Examiner attending physician end for use as the buriel-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disaesa or Injury that initiated events resulting in deeth) Last Dua to (or as a consequence of): Box 68760 certificate be Physician/Medical Dua to (or as a consequence of) P.O. the a Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t d be detect 1 Yes 2 No 3 Probably 4 Unknown Records, þ page 2 should Completed 24a. Was an autopsy 24b. Wara autopsy findings been performed? completion of cause of death? certificete hes 1 Yas 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Wes cesa rafarred to medical Be 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No 10 After this 28c. Injury at Work? 27. Menner of Deeth 28b. Tima of 28d. Describe how injury occurred Certification: Division 1 Naturel 5 Panding invastigation death. 1 ☐ Yes 2 ☐ No 2 Accident i or Attend after death Director: / 6 ☐ Could not be 3 Suicide 28a. Place of Injury - At homa, farm, street, fectory, office building, atc. (Spacify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) P 4 Homicida To the Hospital within 24 hours a To the Funeral Completely filled Cortifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the causa(s) and mannar as stated.

| Cortifying Physician: To the best of my knowledge, death occurred at the time, due to the causa(s) and mannar as stated.

| Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar stated. 29a. Cartifiar edicai (Check only one) 29b. Signature-40d title of certif 29d. Dete signed (Month, Day, Year) 29c. Licensa number roon who countied causa of daath (Itam 23e) (Type, Print) Pr SAUSBURY 6 IVERSIDE AUL FLEUR 540 31. Date filed (Mont) 32. Registrar's Signeture State Registrar



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 2 1 2 0 5

				Ce	ertifica	te of	Death		Reg.	No.		
	1. Decedent's Name (First, Middle,	Last)	TO IS	450				2. Dete of		Day		3. Time of Death
Physician /Medical	Joseph	Goti	ch					June		Day 1999	Yeer 3	3:15 PM
/Medical Examiner	4a Facility Neme (If not institution,					T	4b. City, Town,	or Location of De	-	4c. County		
	Crofton Convale	scent &	Rehab.	Center			Crofto	on	I	Anne A	Arundel	
neral	5. Social Security Number 6	. Sex	7. Age (In yrs	. last birthday		er 1 Year	If Under 24 H	Is. 9 Date of	Birth		9. Birthplec	e (Stete or Foreig
ctor	173-16-5235 Usuel Residence of Decedent	1∏M 2□F	80	Yrs.	Months	Deys	Hours M	Feb.	18,	1919	Pennsy	lvania
10	10a. Stete 10b. County		10c. C	ity, Town or L	ocation						10d.	Inside City Limits
Director		Arunde1		Annaj	7							1 ☐ Yes 2 ☐ No
	10e. Street and Number 2578 Twin Land	ing Cove	2		101. Z	ip Coda 21	401		10g.		What Country's USA	?
Funeral	11. Meritel Stetus	12. Wes De	cedent Ever in U	J,S. 13.	Was Dec	edent of	Hispanic Origin?	(Specify Yas or	No-		e - American	
by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	W Vac G	orces? 2 □ No live Dates: W.W.	II	1 Tes, sp	110	Specify:	ieno Fican, etc.)		Specify	ck, White, etc. y: Whit	
pete	15. Decedent's (Specify only highest)		1	16a. Deci	edent's Use	uel Occu	pation during most of a	working	16b	. Kind of B	usiness/Indus	try
Completed	Elementery/Secondary (0-12)		(1-4or 5+)	lifa.	do wor	use retire	ed)	HOIKING		Aerons	autics	
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Be o	17. Father's Neme (First, Middle, La George G							Neme <i>(First, Mide</i> Lava (un			ne)	
To	19e. Informant's Name/Relationship			19b. Mai	ling Addras	s (Stree	t and Number or	Rural Route Nu	nber, Ci	ity or Town,	State, Zip Co	ode)
	Emily Gotich/ Da	ughter		25	in i	r em	10					
	20a, Method of Disposition			Place of Disp	osition (Ne	me of		Dete	200	. Location	- City or Town,	State
	1 ☐ Burial 2 A Cremetion 3 4 ☐ Donation 5 ☐ Other (Spe		Stete	cemetery, cre				6 05 0	A 4-			
_	21. Signature of Funeral Service Lic		Me	etropo	Litan	Cre	matory	6-25-9	9_A.	Lexand	dria, V	Α
8	11/2/1/1/1/				eorg	e P.	Kalas I	Funeral	Home	9		
	23a. Pert1. Entar the disease, or co	2						land Rd.			er, MD	21037
for use as the burial-transit	Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disease or Injury that inhitated events resulting in death) Last	ь. <i>А</i> му		or as a conse	ates a	<u>                                     </u>	Schrou	/			2	month
be detached for use by Physician/N												
Physician	Part II. Other eignificant conditions	contributing to	seath but not re	sulting in tha	undarlying	causa gi	ven in Part I.			cco uee co	ontribute to th	ne cause of death ply 40 Clinknov
by P										2.2.440		7 12 10111110
Completed			. 3						ss an e		availa	sutopsy tindings ible prior to letion of cause ith?
To Be Comp				~				11	Yes	2 💢 No	1 D Y	
O	25. Wes case reterred to medical	1					26 Place of [	Death (Check on	1000	-X		
o Be	examiner?	Hospital:	Innations 20	] CD (Outpotic	ent 3 C	04 01	her	a Home 5□ R		• 6 DOW	nes (Canaibs)	
To To	27. Manner of Death	28a. Date	of Injury	28b. Time	-	28c. Inju		28d. Dascril				
tlor	1 Neturel 5 Pending 2 Accident investigat	(Moi	nth, Day Year)	Injury	М		ork? ]Yes 2□No					
Certification:	3 Suicide 6 Could not 4 Homicide detarmine	208. Plac	e of Injury - At h ling, etc. (Speci	noma, term, s	treet, tacto	ry, office			n (Stree Town, S		ber or Rurel R	oute Number,
edical C		aminer: On the t						ace, and dua to t ocurred at tha tim				
¥ ×	29b. Signeture and title of certifier	9110 11191			29	c. Licen	se number		29d.	Deta signe	ed (Month, Day	y, Year)
Medical Certification: 7	De la						8958		6	124/9	79	
	30. Nama and addrass of person who DALTEET SING	_	se of death (the	m 23a) (Type 3 ANN	Print)	IS I	ROAD 7	4106,0	DEI	VTON	MD	21113
State	31. Dete tiled (Month, Day, Year)		Registrar's Sign		-							

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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 2 1 2 1 6

	Decedent's Name (First, Middle, Last)		Centiti	cate of	Death	2. Date of De	Reg. No.		3. Tima of Death
Physician	DONNIA TWINI GRAND					JUNE	Day	999	7-52 AM
/Medica Examine	de Feellite Name (Id and Institution of a s	treet and number)	- 111		4b. City, Town, or			of Deviv	
	NOETH ARUNDEL	HOSTITAL			PLEN B		ANNE		LUNDEL
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs.		Under 1 Year onths Deys	If Under 24 Hr. Hours Mir		rth ay, Year)	9. Birthp Coun	place (State or Foreign
Director	214-66-1202 Usuel Residence of Decedent	44	113.			4-28-1	1955	MARY	LAND
Mary Mary	10a. State 10b. County	10c. Ci	ty, Town or Location	n	-			1	0d. Inside City Limits
Mur at the state of the state o	MARYLAND ANNE ARU	NDEL GL	EN BURNIE						1 ☐ Yes 2X No
or 28a-7	10e. Street and Number		1	Of. Zip Code			10g. Citizen of	What Coun	ntry?
				21061			U.S.A		an to do
020	1 Never Married 2 Narried 3 Nidowed 4 Divorced	2. Wes Decedent Ever In U Armed Forces? 1 ☐ Yes 2 ☐ Mo If Yes, Give Year or Dates:		res 2 No	dispanic Origin? ( en, Mexicen, Pue Specify:	rto Rican, etc.)	Specify	ck, White,	
5-0 72 ho	15. Decedent's Educ (Specify only highest grade		16a. Decedent'	of work done	during most of we	orkina	16b. Kind of B	usiness/inc	dustry
121215-0 ed within 72 ho vyglene. ee than "netur it, the Medical.	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO f	IOT use retire	d)				
D d 2			PROPER	TY MANA		ame (First, Middle	APARTME		EASING
ylanc ylanc worth to fi	Ď .				HELEN				
and M	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing A	ddress (Street	and Number or F	Rurai Route Numb	ber, City or Town,	State, Zip	Code)
A M	CALVIN GEYER (HUSBA				E. N.W.	GLEN BUR	NIE MARY	LAND	21061
EVER, DOUNG Together the state of the state of the state and Mortal Hygiene. That it should be fined within the fisher that it should be shown that it is marked other than my or other traumatic event, the Mortal Hygiene.	20e. Method of Disposition  1 🛪 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from Stete	Place of Disposition cometery, cremato	ry or other pla		Date 6-22-19	20c. Location		CITY. MD
Baltim Bantiment Department Important: 1 any injury o	21. Signature of Fundat-Service License	0	22. Na	me and Addre	ess of Fecility	UOME D	7		
Physician	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one			-		GLEN BU	RNIE, MA	RYLA	ND 21061 Approximate Interval Between Onsel and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a.	SEPTI	or as a consequen		CK			1	1 DAY
70 75 25		CHRONI		NAL	FAIL	URE			5 YEARS
58760, cata be executed physician and s the buriel-transit	Sequentially list conditions,	Due to (	or as e consequen	ce of):					
68760, ficata be ex physician is the burie									
6876( fficata be physicia se the bur	resulting in death) Last	Due to (	or as a consequenc	e of):					
OX n certi	d.							i_	
death	Part II. Other significant conditions cont	ributing to death but not res	sulting in the under	lying ceuse giv	ven in Part I.	23b. Did	I tobecco uae co	ntribute to	o the cause of death?
S, P.O. BOX set that the death cert igned by the attending be deteched for use it	MYOCARDIA	L INFAF	RCTIO	7		1□	Yes 2□ No	3 Pro	bably 4 Unknown
Cord requir should						24e. Wer	s en eutopsy formed?	av	fere autopsy findings esileble prior to mpletion of cause death?
Vital Relational Procession of the sample of						10	Yes 2 No		☐ Yes 2 No
/ital	25. Was cese referred to medical				26. Place of De	eath (Check only			
of Vi	examiner?	ospital: 1 1 Inpatient 2	ER/Outpatient 3	DOA Oth	her: 4 Nursing	Home 5□Res	sidence 6 DOtt	ner (Specif	(5)
ng Ph fter th		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju		28d. Describe	how injury occur	red	
Division C balor Attending P 73 after death at Director: After t led in by the funer	2 Accident investigation 3 Suicide 6 Could not be 4 Homlcide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street,		Yes 2□No		(Street and Numi own, State)	ber or Rure	al Route Number,
Division of Vital Rewining the Hospital or Attending Physician: The lighting 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	29a. Certifier 1 Cartifying Physic (Check only one) 2 Medical Examina	clan: To the best of my kno er: On the basis of examina end manner steted.							
o the o the comple	29b. Signature end title of certifier	//	44.5	29c. Licens			29d. Date signe		
- + + + 0	1 Yal	can,	40	D	4696	52	JUNE	= 15	8, 1999.
	30. Name and address of person who con	npleted cause of death (Ite	m 23a) (Type, Print ARUND						
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature	i					
Registrar	MM 2 3 10	THE PERSON NAMED IN	- 40	1200	45.3				

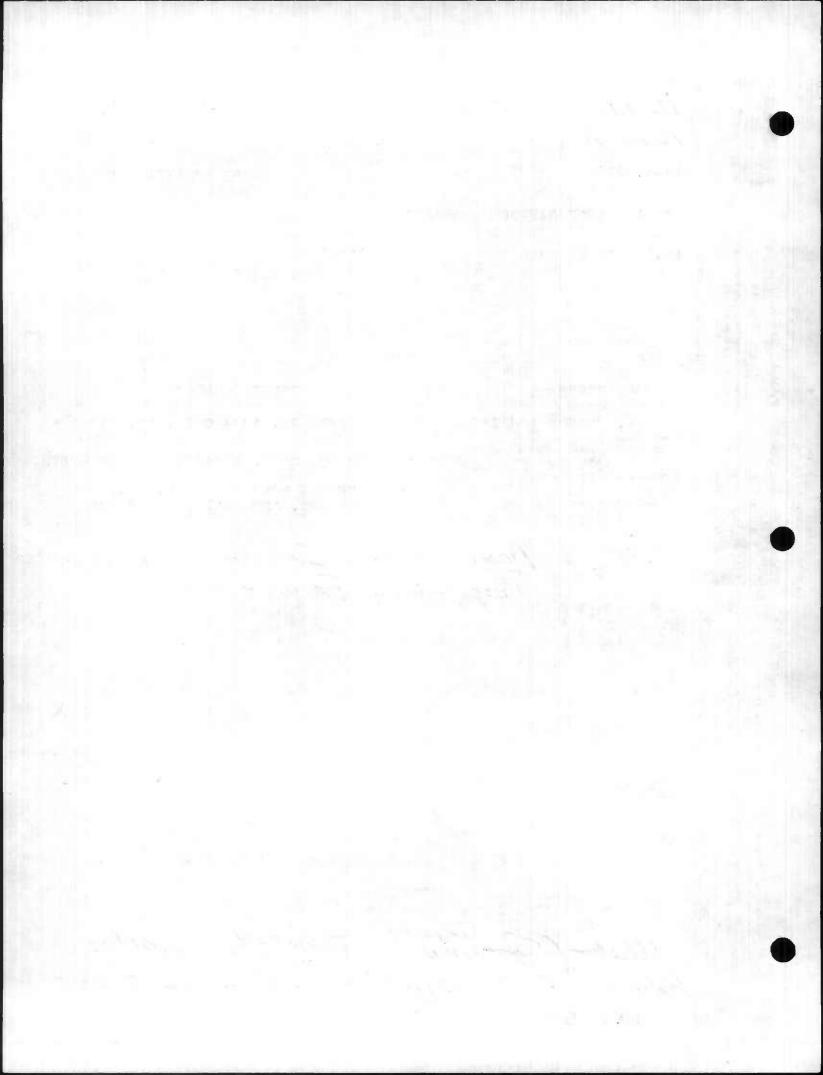
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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** TENSON JUNE 0059 /Medical 4a Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Arunde polis INA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months Days 1 M 2 F Hours 218-44-2105 Director 12 1921 MARYLAND Usual Residence of Decedent the Manyland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits WOHe Examiner must be notified at ANNE Director MARYLAND ARUNDEL ANNAPOLIS 1 Yes 2CNio 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or hams 23a or 1641 COLBERT ROAD 21401 US Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 72 hours after 1 Yes 2 No If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: p 3 ☐ Widowed 4 ☐ Divorced Year or Dates: BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7. Department of Heelth and Menfal Hygiene. Important: If item 27 is marked other than "na any injury or other treumatic avent, the Menta page. Elementary/Secondary (0-12) College (1-4or 5+) 6th 0 HOMEMAKER HOME 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 8 JOHN GREEN BESSIE COLBERT 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACOB W. HENSON (HUSBAND) 1641 COLBERT RD. ANNAPOLIS, MD. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ASBURY BROADNECK CEME. 6/24/99 ST. MARGARETS, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WM. REESE & SONS MORTUARY, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final CAYDIAC FICIENCY disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last pue Due to (or as a consequence of) 68760 physician Physician/Medical Due to (or as a consequence of): Box ( P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? s been signed by the should be detached 3 Probably 4 Unknown 1 Yes 2 No Records, PV 24b. Were autopsy findings available prior to Completed 24a. Was en eutopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attanding Physicien: 24 hours after death. Funeral Director: After this certifice director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 No Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled a Funeral C edicai within 24 hour To the Funer completely fill 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 1 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) eputy 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo lones 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUN 2 3 1999 Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Data of Deeth 3. Time of Death Month **Physician** HuliNE HARMON 3:40 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** GATEWAY SALISBUR Wiczmico OCEAN KESIDENCE 7. Age (In yrs. last birthday) If Under 1 Year If Undar 24 Hrs 5. Social Security Number 9. Birthplaca (State or Foreign Country) MALYLANd 6. Sex 8. Dale of Birth (Month, Day, Year) **Funeral** Days 1 M 2 214-32-623 MAR. Director 2/1936 Usual Residence of Decedent the Marylend 10c. City, Town or Location 10a. Slate 10b. County 10d. Insida City Limits 7 is marked other than "natural", or Itama 23a or 28a-f shor traumatic avent, the Medical Examinar must be notified at 1 785 2 No Directo SALISBUE Md WICOMICO 10e. Street and Number 10f. Zip Gode 10g. Citizen of What Country? 28712 OCEAN SAFELDA USA 21861 by Funeral death 12. Was Deceden Ever in U,S. Armed Forces? 1 ☐ Yes If Yes, Give Yaar or Datas: 14. Raca - Amarican Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. If Itam 27 is marked other than "natural", or item 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 Ne Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SE( DAY-CARE Em 12 18. Mother's Name (First, Middle, Maiden Semame) 17. Father's Name (First, Middle, Last) GIZORY KOBERTA Codington E 19a Informent's Name/Relationship (Type, Pint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zie Code) 1127 Christina ast/EU DASTROL AJE Md. 21804 -5. other t 20a. Method of Disposition 20b. Piaca of Disposition (Name of camatery, crematory or other place) Date 20c. Location - dity or Town, Stala 1 Dental 2 Cramation 3 Removal from State any injury or Canatrey 4 ☐ Donalion 5 ☐ Other (Specify) MARYLAND VA 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility Smith (917 W. ISAbella St 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner the buriel-transit Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events rasulting in death) Last pue Due to (or as a consequence of): requires that the death certificate be exec Division of Vital Records, P.O. Box 68760 ettending physician Physician/Medical Dua to (or as a consequanca of): S 980 to signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 or Attending Physician: funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) No Other: 4 Nursing Homa Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Yaar) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of After 5 Pending Investigation Natural 1 Yes 2 No death. 2 Accident To the Hospital or Attent within 24 hours efter deatl To the Funeral Director: 6 Could not be determined 3 Suicida 28f. Location (Straet and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the ceuse(s) 29a. Certifier Medical completely (Check only

State Registrar

**DHMH 16 Rev 6/95** 

266. Signature and title of certi

31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 1 4 1999

MI

Neme and address of person who completed cause of death (Item-23e) (Type, Print)

SUALL

5

29d. Date signed (Month, Day, Year)

5 AUSBUR

the state of the same of the same of

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ()

Certificate of Death 1 Decedant's Nama (First Middle Lest) 2 Data of Death 3 Time of Death Month **Physician** HEARN 1035 MERLE WILLARD June 12, 1999 /Medical 4b. City. Town, or Location of Deeth 4a Facility Neme (If not institution, give straat and number) 4c. County of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 7. Aga (In yrs. last birthday) If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, Year) 6. Sex 1 M 2 ☐ F 5. Social Security Number 9. Birthplaca (Stata or Foreign **Funeral** Yrs. 213-22-7009 85 Director MARYLAND JAN. 13,1914 Usual Rasidance of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Manyland neart of Health and Mental Hyglene. Inter of Health and Mental Hyglene. Int: If Item 27 Is a marked other than "natural", or items 23s or 28s-f show any or other traumatic event, ma Medical Experiment any or other traumatic event, ma Medical Experiment and the natural or natural and any or other traumatic event, ma Medical Experiment and the natural or natural and any or other traumatic event, ma Medical Experiment and any other traumatic event, ma Medical Experiment and any other traumatic event, ma Medical Experiment and any other traumatic event, may be a second and any other traumatic event, and the second and any other traumatic event. 10a State 10b. County 10c. City, Town or Location 10d. tnsida City Limits 1 Yas 2 No Directo MARYLAND WICOMICO SALISBURY 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Coda 7240 ZION CHURCH RD 21804 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ᡚ No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indian, Black, Whita, atc. Was Dacedant of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Maxicon, Puarto Ricon, atc.) 1 □ Navar Marriad 2 □ Married 1 Yas 2 No Specify: þ 3K Widowed 4 □ Divorced WHITE Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Collaga (1-4or 5+) CARPENTER CRISCRAFT 8 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) P. WILLARD HEARN EVA BELLA DENNIS 19a. Informant's Name/Ralationship (Type, Pnnt) 19b. Mailing Addrass (Straat and Number or Rural Routa Numbar, City or Town, Stata, Zip Coda) WAYNE DAVENPORT - SON IN LAW 604 SHERWOOD CIRCLE SALISBURY, MD 21804 20b. Place of Disposition (Name of cematary, cramatory or other piece) 20a. Mathod of Disposition 20c. Location - City or Town, State Department of Important: If It any Injury or o 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) BOWEN CEMETERY 6/15/99 NEWARK, MARYLAND 21. Signatura of Funaral Sarvice Licensas 22. Nama and Addrass of Facility 705 E. MAIN ST. BOUNDS FUNERAL HOME INC. SA

Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line. BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 Approximate Intervel Batwaan Onset and Death Physician Immediata Causa (Final disaasa or condition rasulting in daath) /Medical Examiner Examiner that the death certificate be executed Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Dua to (or as a consequence of) physician the buria Physician/Medical that initiated avants rasulting in daath) Last Due to (or es e consequanca of): 88 980 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. fibrillation 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings avellable prior to 24e. Wes en eutopsy performed? Completed completion of cause of death? certificate has b lirector, pege 2 s 25. Was casa rafarrad to medical axaminar? Be 26. Placa of Daath (Chack only ona) To Hospital: 1 Yas ANO Othar: 4 □ Nursing Homa 5 □ Rasidanca 6 □ Othar (Specify) 1 Appatiant 2 ER/Outpatient 3 DOA After this funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 28b. Tima of 5 Panding 1 Yas 2 No death. Invastigation 2 Accidant ofter deat Director: 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 24 hours e 29a. Certifian Certifying Physician: To tha best of my knowledga, death occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. edicai (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. To the Vithin 2 29b. Signatura and titla of certifier 29c. Licansa number 29d. Date signed (Month, Dey, Yeer) D36576 30. Nama and addrass of person who complated causa of death (Itam 234) (Type, Print)

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

700

31. Data filed (Month, Day, Yaar)
JUN 1 4 1999

32. Registrar's Signatura

**DHMH 16 Rev 6/95** 

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Marylar	Certific				Reg. No.	) <u>(</u>	1610
Physic	ian	1. Decedant's Name (First, Middle, Last,			TON	ASSEN	2. Date of De Month	Day	Year	3. Time of Death
/Med Exam		4a. Facility Name (If not institution, give	street end number)		3014	4b. City, Town, or I	ocation of Deatl		1999 of Death	5:00A4
LAdilli	1161	Mariner Health				Clan Bur		Anne		- 2
Funera	Г	5. Social Security Number 6. Set	9 , ,	Mor	Inder 1 Year		8. Date of Bir (Month, De	th		ce (State or Foreign y)
Director		060 -07-7760 Usual Residence of Decedant	M 2□ F 91	Yrs.				12,190		orway
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Man and and and and and and and and and a	io	Maryland Anne Arur	idel Cle	n Burnie						1 ☐ Yes 2√ No
20 after death with the Maryland or Items 23e or 28e-f show miner must be notified at	Director	10e. Street and Number	ide1 ofe		f. Zlp Code			10g. Citizen of V	hat Countr	y?
ath w s 23s nust3		208 Plymouth Lane			21061			United :		
_ 5 22	Funeral		12. Was Dacedent Ever in U Armed Forces?		specify Cub	Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14. Raci	e - Americe k, Whita, et	
5-0020 72 hours after natural, or Its disal Examins	by	1 Never Married 2√2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 🗆 Y	es 2 No	Specity:		Specify		
15-00; 72 hours "natural", edical Ex	ted	15. Decedent's Edu (Specify only highest grad	cetion	16a. Decedant's	Usuai Occu	pation	kina	16b. Kind of Bu	White siness/Indu	
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d 2121 filed within Hygiene. ont, the Me		8 17. Father's Name (First, Middle, Last)		Machinis	t	10 Mother's Non	o (First Middle	Diesel		try
d be fill	o Be	Martin Jonassen							9)	
Maryland 21215-0020 42 should be filed within 72 hours at th and Mental Hygiene. 7 is marked other then "natural", or traumetic event, the Medical Exam	2	19a. Informant's Name/Ralationship (Ty	pe, Print)	19b. Mailing Add	dress (Stree	Hilga Ia t end Number or Ru			State, Zip C	Coda)
and 2	3	Margit Jonassen (Da	ughter In La	w) 1322	Whitma	an Drive	Glen Bu	rnie, M	D 2106	51
Q -115		20a. Mathod of Disposition 1 ☐ Buriai 2 🛣 Cremation 3 ☐ R	James of from Chata	Place of Disposition cemetery, cremetory	or other ple		Date	20c. Location -		
		4 ☐ Donation 5 ☐ Other (Specify)	Cei	esapeake nter, LLC	Cremat	ion	5/21/99	Steven	sville	e, MD
Baltim permit. Pa Department important: sny injury once.		21. Stagature of Funding ServicerLicense	00	22. Nam Sin	e and Addre	ess of Facility Tuneral	Home, F	.A.		
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Physician /Medical		Immediate Causa (Final	A.C.	0.00-00	1 0	112 mm = /12	1.			04
Examiner		disease or condition resulting in death)		81 RATION or as a consequence	a of):	NEURONIA				VAY
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68760, ificate be example of physician and per the burial		cause. Enter Underlying Cause (Disease or injury that initiated evants	·							
<b>U</b>	edicai	resulting in death) Last	Due to (c	or as a consequence	of):					
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of Vital Records, Physician: The law requires the this certificate has been signeral director, page 2 should be o	шр	Deve	NTIA.							eath?
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9 Physical neral	n: T	27. Manner of Death  1 Satural 5 □ Panding	28a. Date of Injury (Month, Dey Year)	28b. Time of	28c. Inju Wo			how Injury occurr		
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Division of Vita within 24 hours effect death.  To the Euneral Director: After this certifica completely filled in by the funeral director,	edicai	(Check only one)	ner: On the basis of examina and manner stated.	ation and/or investige	ation, in my	opinion, daeth occu	rrad et the time,	data and place,	and due to t	ha cause(s)
To the To the comp	Me	29b. Signature and title of certifier	.40		29c. Lican			29d. Date signed	(Month, D	ey, Year)
		1 rung	MD.		D-	22609		JUNE	22-	1999.
Sale Control		30. Name and address of person who co	mpieted cause of death (Iter	m 23a) (Type, Print)		0.0	01.0		_	-
		RUBEN REIDE	A M.D 7	445 FUR	NACE	BRANCH	ROL 6	LEN BUI	MIE	Hd 21060
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State of Maryland / Department of Health and Mental Hygiene 99 2 2 2

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	Physici /Medi		Mary Christin	e Jackson	n							10	1999	Year	2:1	4 AM
	Exami		4e. Facility Name (If not institution, gir	ve street and number,	)				4b. City, Tow	n, or Loc	ation of Deat	h .	4c. County	of Deeth		
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	Manyland f show	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Wicon	nico		y, Town or I								10		e City Limits
	the h	Director	10e. Street end Number	111111111111111111111111111111111111111		Salis	bury	Code				100.1	Citizen of V	What County		,
	23a or	ral Dir	1004 Apt.4 Fa:	irground	Dri	ve		218	01				S.A	vnat Count		
020	n 72 hours effer death with the Maryland "natural", or items 23a or 28s-f show sciosil Examiner mart be notified at	by Funeral	11. Marital Stetus  1 Never Married 2 Married  3 Widowed 4 Divorcad	12. Wes Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates:	7	,S. 13	. Was Deced If Yes, spec 1 ☐ Yes		Hispanic Orlgi pan, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No Rican, etc.)	)-	Blac	e - America k, White, e	etc.	1,
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Maryland	0 0 0 0 0	To Be	Jack Bazemore						Eliza	ahe	th Hi	~kn	nan			
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altimore,	permit. Pegas 1 and 2 should Department of Heelth end Mei Important: If item 27 is marke any injury or other treumatic once.		20e. Method of Disposition  1 🗆 Buriai 2 Cremation 3	Removel from State	20b. F	Placa of Dispendency, cr	position (Nar ematory or o	me of other pla	ic <i>e)</i>		Date /15/99	20c	Location -	City or Tow		
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	Physician /Medical Examiner	er.	23a. Part1. Enter the disease, or con shock, or heart failule. List only Immediate Cause (Final disease or condition resulting in deeth)	e. Metas	fafic	Gr		- 9							Onset e	Between and Death
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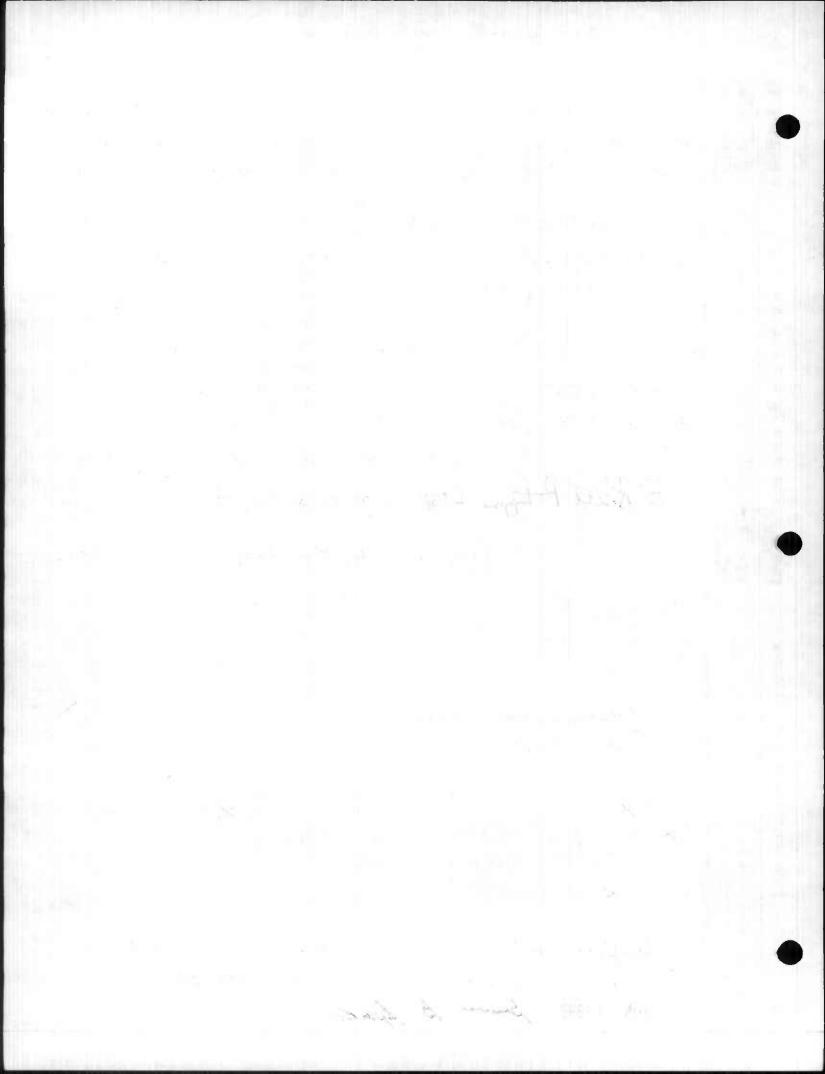
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tor	MARYLAND WORCES	TER	B	BERLIN								M Yas 2 □ 1
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	4 Donation 5 Other (Special		WIC		MEMOR				/16/99			MARYLAND
	21. Signature of Funeral Sarvice Lic	errsea ()	0	22	2. Nama and /	Addrass	s of Facility	/		705 E.	MAIN	ST.
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Spark

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

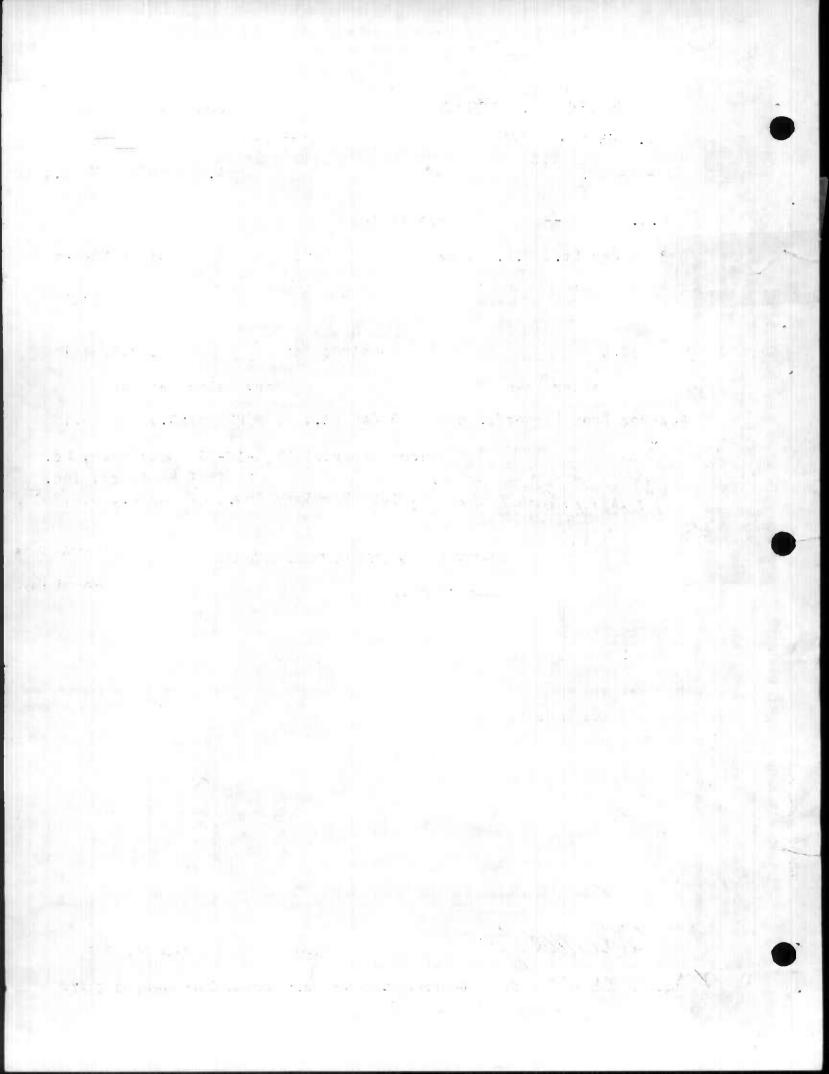


## Please Type or Print In Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 2 2 3

		Ce	rtificate of	Death	Reg	ı. No.	La 1 La 1 V
	Decedant's Nama (First, Middla, Last)			2	Date of Death	Day Ya	3. Time of Death
sician ledical	JOSEPH S. JAC	CKSON	*		June 9		18:48 PM
niner	4a Facility Name (If not institution, give street and number	er)		4b. City, Town, or Loca	tion of Death	4c. County of D	eath
	ST. AGNES HOSPITAL			BALTIMORE		-	
al or	XD(M_2□ F	Age (In yrs. last birthday, 5 4 Yrs.	Months Days	Hours Min.	Data of Birth (Month, Day, Y	ear)	Birthplaca (Stata or Foraign Country)
	578-58-5995 Usual Rasidance of Dacedant	34			ct. 23	1944	Wash., DC
	10a. State 10b. County	10c. City, Town or L	ocation				10d. Insida City Limits
Director	D.C	Washin	gton				1 Yes 2 No
-	10e. Street and Number		10f. Zip Coda		100	. Citizan of What	Country?
Funeral L	3697 Jay St., N.E.	#202	2	0019		United	States
	11. Marital Status 12. Was Deceder Armed Força	nt Evar in U,S. 13.	Was Decedent of I	Hispanic Origin? (Speci pan, Mexican, Puarto Ri	y Yes or No- can, atc.)	14. Race - A Black, W	merican Indian; /hita, atc.
	1 Navar Married 2 Married 1  Yes 2 H Yas, Giva Year or Date:	No	1□ Yas 20XNo			Specify:	Black
Completed	15. Decedant's Education (Specify only highest grade completed)	16a. Dece (Give	edent's Usual Occup a kind of work dona	petion during most of working	16	6b. Kind of Busine	ess/Industry
	Elementary/Secondary (0-12) Collaga (1-4c	or 5+)	onstruc			Cons	truction
	17. Fathar's Nama (First, Middle, Last)	C	Ullstruc	18. Mother's Name (	First Middla Ma		CITICUION
2	Walter Hamm					Jackso	n
-	19a, Informant's Name/Ralationship (Type, Print)	19b. Mail	ing Addrass (Street	t and Number or Rural I			
	Roxanne Froneberger/Co	usin 3697	Jay St	., NE #20	2 Was	h., DC	20019
	20a. Mathod of Disposition	20b. Placa of Disp				C. Location - City	
	1 ☐ Burlat 2 ☐ Cramation 3 ☐ Removal from Sta 4 ☐ Denation 5 ☐ Othar (Specify)			al Pk 6-1	9-99	Lando	ver, Md.
	21. Signatura of Funeral Service Licensee	1 1 2	2. Nama and Addra	ass of Facility Ca	nitol	Mortua	ry, Inc.
	March Shirt	Vallon	125 Max	yland Ave			
-	23a Part 1 Eritar the disease of complications that cause	er the reath Delect as	ter the mode of dvi	ing such as cardiac or	aspiratory arres	wasn.	Approximata
	23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	fine.	na, ma moda or oy	arig, buon ao oananao an	aspiratory arrow		Intarval Between Onset and Death
	Investigation Court (Final)						
	Immadiata Causa (Final disease or condition rasulting in daath)  AC	UTE RESPIRA	TORY DIST	TRESS SYNDR	OME		Several Days
70		Dua to (or as a consa	iquenca of):				Carrage 1 Days
		PIRATION PN					Several Days
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Medical	rasulting In death) Last	500 10 (0) 00 00 00 00	quarrou ory.				
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2	Quadriplegia						
					24a. Was an perform		4b. Wara autopsy findings available prior to completion of causa of death?
					i) Yas	2 No	Nas 2□ No
	25. Was casa rafarred to medical			26. Placa of Death /		20140	70180 20110
0	axaminer?	tion: 2∏ EB/Outpatio	or all DOA Ot	har: 4 Nursing Home		os 6 DOther /	Speciful .
_		1	SIR SLI DOA	4 LI Nuising Home		Injury occurred	эр <del>е</del> сну)
2	27. Mannar of Death  Natural  Accident  The Panding Invastigation  28a. Data of It (Month, It)	Day Year) Injury		ork? ]Yas 2∐No			
Cer Illications	2 □ Politide 6 □ Could not be	Injury - At homa, farm, si atc. (Spacify)	traat, factory, office	28	f. Location (Stre City or Town,	et and Number o Stata)	r Rural Route Number,
edicai	29a. Certifiar (Check only one)  Certifying Physician: To tha be:  2 Medical Exeminer: On tha basis and mannar	of examination and/or in	th occurrad at tha ti nvastigation, in my	ima, data and place, an opinion, daath occurred	d dua to tha cau at tha tima, dat	isa(s) and manna a and placa, end	r as statad. due to tha cause(s)
Z	29b. Signature and different fertifier		29c. Lican	se number	29	d. Data signed (M	fonth, Day, Year)
	· Selleller Nos		D	48054	J	une 10,	1999
,	30. Nama and addrass of person who completed causa o	f daath (Itam 23a) (Type					
	Dr. J. Ross Slemmer St. A	ones Health	Care 900	Caton Aven	ue Rale	imore W	ID 21229
te		strar's Signatura	, )		vart		
rar	JUI 6 1999 <b>•</b>	warmen 19	. Doas	Mail.			

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## Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physicia /Medic Examin

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Example Frust be notified at once.

Physician /Medicai **Examiner** 

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 62 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burlar-transit Division of Vital Records, P.O. Box 68760,

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			,							
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203-12-6841	19 M 2□ F		Yrs. Months			Min. OC	(Month, Da	y, Year)		thpieca (Stete or Foreign buntry)
Usual Residence of Decedent		, 1				qc	L 31	1924	Pel	nnsylvani
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MD Anne	e Arundel	Seve	rna Pa	rk						1√2 Yes 2□No
10e. Street and Number	- III anacı	Deve		ip Code				10g. Citizen of	Whet Co	ountry?
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12		-	JiiiiiuIII	cati						
17. Father's Name (First, Middle	, Last)						rst, Middle,	, Maiden Sumei	me <i>)</i>	
Edward	Lehman				Susa	n	Pu	sh		
19e. Informent's Name/Reletion		19b	. Meiling Addre	ss (Street e	and Number	or Rural F	Route Numb	er, City or Town	, State,	Zip Code)
Regina Lehma	n / wife	30	7 Nor	th D	rive,	Sev	erna	Park.	MD	21146
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State Registrar 31. Dete filed (Month, Dey, Year)

JUN 2 3 1999

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death Amended Item#2 per PhyG773 7/9/99 EW 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** June Helen George Lewnes <del>12</del> 21 1999 6:38 AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare - Spa Creek Center Annapolis Anne Arundel 8. Data of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1□ M 2XF 377-09-5392 April 22,1918 Director Michigan Usual Residence of Deceden 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 No Director Md. Anne Arundel Annapolis 28a-f 200 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 1112 Mitchell Street Berns 23a 21403 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 24☐ No If Yes, Give <sup>1</sup> Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian. o filed within 72 hours after do of hygiene. other than "natural", or item "natural", or Itan Biack, Whita, atc. 1 Nevar Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: À 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Restaurant 12 Owner 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumema) pormit. Pages 1 and 2 should be file.
Department of Health and Montal Hy
Important: If Item 27 is marked othe
any Injury or other traumatic event Be Lula Harakas George Diamond 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Spiro G. Lewnes / son 1117 Mitchell Street Annapolis, MD 21403 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremetion 3 Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Demetrious Cem. 6-24-99 Annapolis, MD. 22. Nama and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service License 147 Duke of Gloucester St. Annapolis, MD 21401 an 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximeta Intarval Between Onset and Death **Physician** 3 DAY /Medical Immediata Causa (Final disaesa or condition resulting in death) Examine her Examiner ician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or Injury thet initieted events resulting in death) Last Due to (or as a consequence of). physician s the burial Box 68760. Physician/Medical Due to (or as e consequence of): 80 950 P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yee 2 No 3 Probably 4 Unknown Records. þ 24b. Ware autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed page 2 a 1 Yas 2€ No 1 ☐ Yas 2 ☐ No of Vital Physician: 25. Wes casa refarred to medical examinar? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 28a. Deta of Injury (Month, Day Year) Certification: Affer Division or Attending 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 5 4 Homicida filled in within 24 hours a To the Funeral C completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course of the cause (s) and menner as stated. edical miner: On the basis of ax (Check only ination and/or investigation, in my opinion, death occurred at tha time, data end place, end due to tha cause(s) 29b, Signature and title of pertifie 29c. License number 29d. Deta signed (Month, Day, Year)

Registrar

State

600 Ridgely

30. Nama and addrass of person who completed causa of death (flem 23s) (Type, Print)

M.D.

32. Registrar's Signature

LaPenta,

JUN 2 2 1999

Michael J.

31. Data filed (Month, Day, Year)

12 2438

Suite 120 Annapolis, MD

To the state of the state of

- 1 F HUL

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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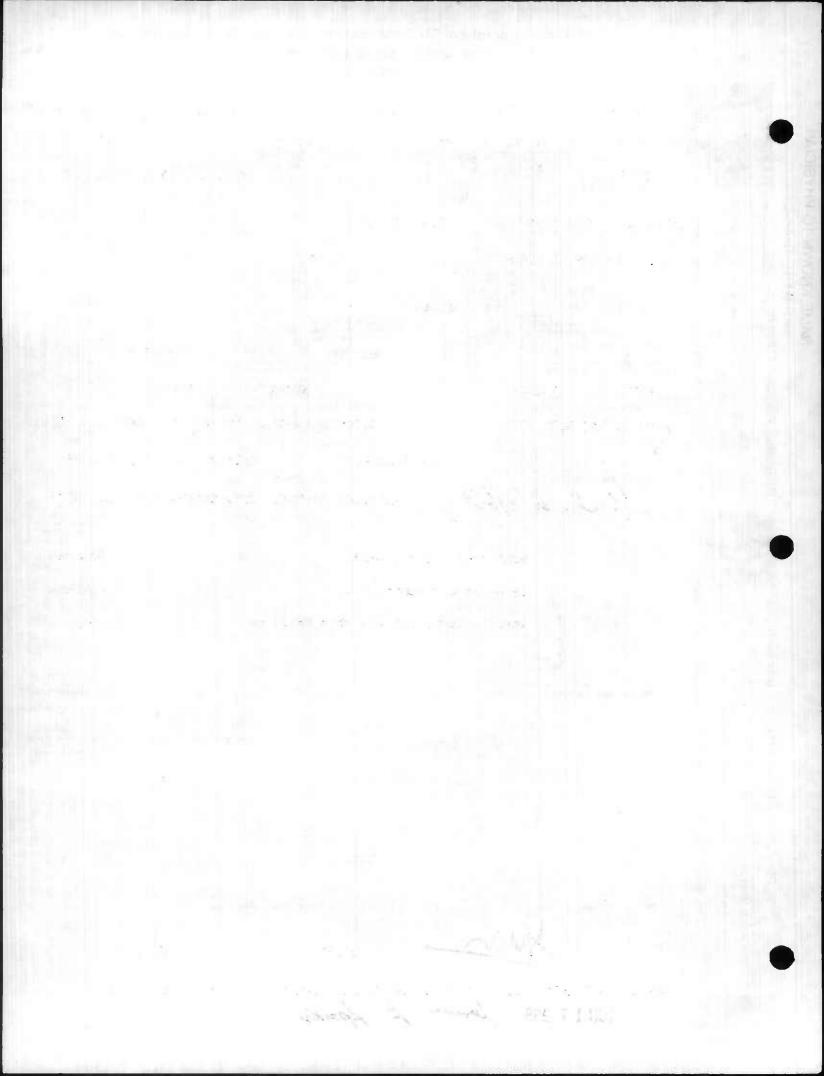
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State Registrar

KARMACHANDRA NATR, M 31. Date filed (Month, Day, Year) JUN 1 7 1999

D., VA Maryland Health Care System, Perry Point, MD
32. Registrar's Signature books

DHMH 16 Rav 6/95



# Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🗦 🖯 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** RONALD 1850 LEEBRICK 1999 NUNE 10 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) if Under 1 Yeer Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** Deys 1 M 2□ F Months Yrs. 60 Director 577-52-5401 November 11,1938 Washington, DC Usual Residence of Deceden the Maryland 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f shor traumstic event, the Modical Examinal must be not fred at 1X Yes 2 No Worcester Ocean City Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 S. St. Louis 21842 USA Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status ifiled within 72 hours efter de I Hygiene. other then "natural", or item Bleck, White, etc. 1 Yes 2 No Navy 1 ☐ Never Married 2 ☐ Married Specify: White 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced Year or Dates: 1955-59 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dishwasher Ember's Restaurant 12 and Mental Hygins Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) should be Frank Lyne Leebrick Clara (unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Heelth and Important: If New 27 Is n Clara M. Leebrick/Daughter 44 E. First ST., Wheeling, WV 26003 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Buriel 2 ☑ Cremation 3 ☐ Removal from State à 6/12/99 Salisbury, MD 5 Other (Specify) 4 Dona Salisbury Crematory 22. Name end Address of Facility
Holloway Funeral Home Professional Association 21. Signa M01051 Pert Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximata Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Physician/Medical Examiner that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events pue Due to (or as a consequence of) attending physician for use as the buria Box 68760 Due to (or as a consequence of): resulting in deeth) Last SB Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the 3 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown adme signed t Records, þ requires 24b. Were autopsy findinga available prior to Completed 24a. Was an autopsy performed? peen completion of cause of death? WE has Tha 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2No 10 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Director: After 1 Netural 2 Accident or Attending 5 Pending 1 Yes 2 No 24 hours efter death. investigation 6 Could not be 3 Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. edical 29a. Certifier (Check only To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier emily 3 no completed cause of deeth (Item 23e) (Type, Print) 30. Name and address of person RODNE) WENRICH 100 POWER STREET SALISBURY

Registrar's Signature

DHMH 16 Rev 6/95

State Registrar

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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** KENNETH 0750 L. McCLURE JUNE 24, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS

If Under 24 Hrs. ANNE ARUNDEL If Under 1 Year 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1) M 20 F Months Days Hours Min 56 Yrs. 175-34-7213 Director Dec. 14, 1942 Pennsylvania Usual Residence of Decedent the Maryland r 28a-f ahow 10a State 10h Counh 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Shady Side Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is merked other than "natural", or items 23s or other traumstic avent, to a Hadical Example, must be a UNITED STATES 1247 Avalon Boulevard 20764 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 12. N/ses 2□No If Yes, Give Year or Dates: 1964–67 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Marital Status 72 hours after 1 Never Married 2/ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Specify: WHITE P 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hyglene.
Important: If item 27 is merked other than "nets any injury or other traumetic avent, the Medica once. College (1-4or 5+) Elementary/Secondary (0-12) 12th Plate Printer Bureau of Engraving 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Kenneth Leo McClure Mary Belle Morris 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Linda L. McClure/ Wife as in item 10 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2XX remetion 3 ☐ Removel from State 6-25-99 Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service recepses 22. Name end Address of Fecility GEORGE P. KALAS FUNERAL HOME ISLAND ROAD EDGEWATER, MD. 21037 2973 SOLOMONS 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examine eriosclerot physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated assets. Due to (or as a consequence of) Box 68760. that the death certificate be Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) 158 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown Division of Vital Records, p 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to Completed Deed 8 available prior to completion of cause of death? page 2 certificate has 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 No 2 No To 1 | Inpatient 2 | ER/Outpatient 3 | DOA this funaral 28a. Date of Injury (Month, Day Year) ne Hospital or Attanding Ph in 24 hours after death. The Funeral Director: After the pletaly filled in by the funeral 27 Menner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturat
2 Accident 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29b. Signature and title of certified 29c. License number 29d. Dete signed (Month, Day, Year) eputy JUNE 24,1999 ulle mo 30. Name and address of person who complete se of death (Item 23a) (Type, Print) WILLIAM P. JONES M.D 6131 SHADY SIDE ROAD SHADY SIDE, MD. 20764 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 2 5 1999 Registra

**DHMH 16 Rev 6/95** 

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	ve Hospital or / n 24 hours after ve Funeral Dire plately filled in b	edical	29a. Certifier (Check only one) Certifying Pl	nyaician: To the bes miner: On the basis end menner s	of examin	owledge, dea etion end/or l	th occurred	d et the tin n, in my o	ne, dete end plece pinlon, deeth occu	, end due to the rred et the time	cause(s) and n , date end piece	nenner as st	ated. the ceuse(s)		
	To the within 2 To the compla	Ň	29b. Signature end title of certifier					c. Licens		T	29d. Date sign		Dey, Year)		
			11/	1 aus				DZY	986 B101 Sa		6/17/	99			
	-		30. Name end eddress of person who		deeth (Ite	m 23e) (Type	Print)				-/ /				
	7		Robert J. Red				de 1	Dr. 1	B101 Sa	lishur-	md. 2	1601			
	Sta	te	31. Dete filed (Month, Day Year)	32. Regis			,								
	Registr		a landa JUNI	7 1444	Mary	was	14								

DHMH 16 Ray 6/95

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**Physician** 

/Medical

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10a. State

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**Funeral** 

Director

7 is marked other than "nature!", or items 23a or 28a-f show traumstic event, the Moulcal Examiner must be notified at

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and Mental

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**Physician** 

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Examiner

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Pages nent of t Department of Important: If it eny injury or o

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Dete of Deeth 3. Time of Death Jesse Medeiros 1999 0548 4b. City, Town, or Location of Death 11, 19 9 9 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. Birthplece (Stete or Foraign Country) 5. Social Security Number 8. Date of Birth 1⊠M 2□ F Months Hours Min Yrs. 075-16-8433 Mass. Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits X□ Yes 2□ No Delmar Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 21875 1101 Maple St. 12. Was Decedent Ever in U,S. Armed Forces? 1 ₩ Yes 2 □ No If Yes, Give Year or Detes: ₩WII 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Maritel Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorcad 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Private Mechanical Engineer 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Marie Manuel Medeiros Souza 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1101 Maple St. Delmar, Md. 21875 Eleanor D. Medeiros, Wife 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 N Burlel 2 ☐ Cremetion 3 ☐ Removal from Stete 6 - 15Delmar, Md. Melsons Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Servica Licensee 22. Name and Address of Fecility Short Funeral Home, Inc. 13 E. Grove St. Delmar, De. 19940 23a. Pert1. Enter the livese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete intervel Between Onset end Deeth Arterior elevotic Heart Tisease Immediete Ceuse (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es e consequença of) Due to (or es a consequenca of): 23b. Did tobacco use contribute to the cause of death? 1 Pres 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 3 No 1 Yes 2 No

attending physician and for use as the bunel-transit death certificate be executed the signed by Records, Deed certificate Division of Vital Physician: this funeral After or Attending death. within 24 hours after deat To the Funeral Director: 6

Physician/Medicai thet initieted events resulting in deeth) Last Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. by Completed 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homiclde 29e. Certifier edicai (Check only

1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and menner as stated. 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and pieca, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) 105 Pine Rolling Completed Cause of deeth (Item 23e) (Type, Print) 105 Pine Rolling Completed Cause of deeth (Item 23e) (Type, Print) 105 Pine Rolling Completed Cause of deeth (Item 23e) (Type, Print) 105 Pine Rolling Completed Cause of deeth (Item 23e) (Type, Print) 105 Pine Rolling Completed Cause of deeth (Item 23e) (Type, Print) 105 Pine Rolling Completed Cause of deeth (Item 23e) (Type, Print) 105 Pine Rolling Completed Cause of deeth (Item 23e) (Type, Print) 105 Pine Rolling Completed Cause of deeth (Item 23e) (Type, Print) 105 Pine Rolling Completed Cause of deeth (Item 23e) (Type, Print) 105 Pine Rolling Completed Cause of deeth (Item 23e) (Type, Print) 105 Pine Rolling Completed Cause of deeth (Item 23e) (Type, Print) 105 Pine Rolling Completed Cause of deeth (Item 23e) (Type, Print) 105 Pine Rolling Completed Cause of deeth (Item 23e) (Type, Print) 105 Pine Rolling Completed Cause of deeth (Item 23e) (Type, Print) 105 Pine Rolling Completed Cause of deeth (Item 23e) (Type, Print) 105 Pine Rolling Completed Cause of deeth (Item 23e) (Type, Print) 105 Pine Rolling Completed Cause of deeth (Item 23e) (Type, Print) 105 Pine Rolling Completed Cause of deeth (Item 23e) (Type, Print) 105 Pine Rolling Cause of deeth (Item 25e) (Type, Print) 105 Pine Rolling Cause of deeth (Item 25e) (Type, Print) 105 Pine Rolling Cause of deeth (Item 25e) (Type, Print) 105 Pine Rolling Cause of deeth (Item 25e) (Type, Print) 105 Pine Rolling Cause of deeth (Item 25e) (Type, Print) 105 Pine Rolling Cause of deeth (Item 25e) (Type, Print) 105 Pine Rolling Cause of deeth (Item 25e) (Type, Print) 105 Pine Rolling Cause of deeth (Item 25e) (Type, Print) 105 Pine Rolling Cause of deeth (Item 25e) (Type, Print) 105 Pine Rolling Cause of deeth (Item 25e) (Type, Print) 105 Pine Rolling Cause of deeth (Item 25e) (Type, Print) 105 Pine Rolling Cause of deeth (Item 25e) (Type, Print) 105 Pine Rolling Cause of deeth (Item 25e) (Type, Print) 105 Pine Rolli

Registrar

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31. Dete filed (Month, Dey, Year)

Registrer's Signeture

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State of Maryland / Department of Health and Mental Hygiene 99 2 2 2

			Certificate	of Death	,0	g. No.	61661			
	Oharataia	Decedent's Name (First, Middle, Last)		IN THE STATE OF	2. Date of Deeth Month	Day Yes	3. Time of Death			
le.	Physiciar /Medica	Andre Eric Brenso	n	Price	June 15.		10:45 AM			
	Examine	A. F. 100 . 81		4b. City, Town, or Lo		4c. County of D				
		Salisbury Center: Genesis Elder	Care	Salisbury	. MD	Wicomi	CO			
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs	s. last birthday) If Under 1 Y	eys Hours Min.	8. Dete of Birth (Month, Day, Mar. 13	Year) 9. f	Birthplace (State or Foreign Country)			
	Director	216-54-9710 <sup>1</sup> X <sup>M</sup> <sup>2□ F</sup> 49	Yrs.		Mar.13	1950 M	aryland			
	put *	Usual Residence of Decedent  10a. State 10b. County 10c. C	City, Town or Location				10d. Inside City Limits			
	sho						1 ☐ Yes 2 No			
	the N	Maryland Wicomico S  10e. Street and Number	Salisbury	do	10	g. Citizen of What				
	ith with the Marylar 23s or 28s-f show			801	10		Country			
	ns 23	11. Maritel Status 12. Was Decedent Ever in the			ocity Ves or No.	U.S.A	merican Indian,			
21215-0020		11. Maritel Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in 6 Armed Forces? 14 Yes, Give Year or Dates: 196	1□Vac aM	of Hispanic Origin? (Spe Cuban, Mexican, Puerto No Specify:	Rican, etc.)	Bleck, W	hite, etc.			
Ŏ	2 ho	15. Decedent's Education	16a. Decedent's Usual O	ccupation	1	6b. Kind of Busine	ss/industry			
2	within 7 ene. than "n	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give kind of work di life. DO NOT use n	one during most of worki etired)						
7	d withi	2	Laborer			None				
D	be filed tal Hygi d other event,	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, M	aiden Sumeme)				
Va Na	Went Went riked riked	Omar B.Jones SR.	10000000	Helen	Price					
Maryland	and and	19a. tnforment's Name/Raletionship (Type, Print)	19b. Meiling Address (St							
	and n 27 n 27	Della Price (Wife)	6300 Rocka							
altimore,	Pages 1 an nent of Heal int: If Itam 2 iry or other	Description 3 Linemove from State	Place of Disposition (Name of cemetery, crematory or other Cem. Easter	1 6	Simi	Oc. Location - City  Iurlock,				
Balti	permit. Pa Departmen Important: any injury pncs.	21. Signature of Funeral Service Licensee	22. Name and A Stewart		Home					
		23a. Part1. Enter the disease, or complications that caused the deashock, or heart failure. List only one cause on each line.					Approximate Interval Between			
4	Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Due to	ors of Mul	type So	bros	-3	MANY Yest			
68760,	v requires thet the deeth certificata be assected been signed by the attending physician and should be detached for use as the bunal-trensit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	(or as a consequence of):							
	th certification to the season of the season									
-	the all	Part II. Other algnificant conditions contributing to death but not re	sulting in the underlying caus	e given in Part I.	23b. Did tob	acco usa contrib	uta to the cause of death?			
s, P.O.	requires thet the deeth cer been signed by the attendir hould be detached for use	HISTOR ON, Seny	ne Disord	er,	1 □ Ya	a 20 No 3	Probably 4 Unknown			
Vital Records,	The law requires thet the deeth cert cate has been signed by the attending page 2 should be detached for use	Bumoness			24a. Was en perform		b. Were autopsy lindings available prior to completion of cause of death?			
Ť	The law				1 ☐ Yes	s 2 No	1 ☐ Yes 2 ☐ No			
E	entifica ector. g	25. Was case referred to medical		26. Place of Deeth	(Check only one	)				
	hysic li dire	1 ☐ Yes 2 Ø No Hospitel: 1 ☐ Inpalient 2 ☐	□ ER/Outpatient 3□ DOA 28b. Time of Injury 28c.		me 5 Resider 28d. Describe hov	nce 6 Other (S	Specify)			
0	eeth. or: Al	2 Accident investigation		1 ☐ Yas 2 ☐ No						
Division of	tal or Attending Prise that death.  al Director: After the indirector that the funeral control of the funeral floation.	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Special Could not be determined building, etc.)	home, larm, street, lectory, of lfy)	fice	281. Location (Str. City or Town,	eet and Number or State)	r Rural Route Number,			
	To the Hospital within 24 hours To the Funeral I completely filled	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my kn  2 Medical Examiner: On the basis of examination and manner stated.	Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the called and manner stated.							
	withir To the comp	29b. Signature and the of certifier	29c. Li	cense number	29	d. Dete signed (Mi	onth, Day, Year)			
		1/lle		)3981B		6/15	-199			
	11	30. Name and address of person who completed cause of death (Ite	m 23a) (Type, Print)	- PRme	Sples	s mo	21204			
	State	31. Dale lifed (Month, Day, Year) 32. Registrar's Sign	nature		/	1.				
	State Registrar	IIIN 1 C 1000	41							

DHMH 16 Rav 6/95

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State of Maryland / Department of Health and Mental Hygiene	99	2	12	2:	2
Certificate of Death			l bon	line 1	ju dij

					Cert	tificate d	of Death	7	F	Reg. No.		a I in	ha ha	
		1. Decedent's Name (First, Middle, Las	1)				100		2. Date of Dea	ith	Ver	3. Time	of Death	
Phys /Me		CDAOR	E			OAKES			06	$oldsymbol{14}^{ extsf{Day}}$	Year 99	110	4	
Exan		An English blome (Mant in this size of a star of and sure trans-				4b. City, Town, or L			cation of Death	4c. County	of Deeth			
		PENINSULA REGIONAL	L MEDICAL	CENTER			SALIS			WICOM	ICO			
Funera Directo		5. Social Security Number 6. Second 11 O71 - 22 - 7764 Usual Residence of Decedent	X 7. Age □M 2XF	e (In yrs. last b 72	oirthday) Yrs.	If Under 1 Y		Min.	8. Date of Birth (Month, Day April 8,	h , <sub>Year)</sub> 1927	9. Birthp Cour New	olace (State otry) York	te or Foreign	
and and		10a. State 10b. County		10c. City, To	wn or Loc	ation					1	Od. Inside	City Limits	
Mery right	ţ	New York West Ch	nester	New.	roche	elle						TEY	as 2 No	
r 28s	Director	10e. Street and Number				10f. Zip Cod	le			10g. Citizen of	What Cour	ntry?		
h wit						10	801			USA				
Maryland 21215-0020 d 2 should be filed within 72 hours efter death with the Meryland th end Mental Hygiene. T is marked other than "natural", or Hems 23a or 28a-f show traumetic event, the Medical Examiner must be incritised at	by Funeral	3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:				of Hispanic O Cuben, Mexics No Specify		cify Yes or No- Rican, etc.)		14. Race - American Indian, Bleck, White, etc. Specify: White			
15-0	Completed	15. Decedent's Edi	ucation	16	a. Decede	ecedent's Usual Occupation live kind of work done during most of working fe. DO NOT use retired)				16b. Kind of B	usiness/in	dustry		
2121 d within giene. r then '	noie	Elementary/Secondary (0-12)	Elementary/Secondary (0-12) College (1-4or 5+)				tired)	ISCOI WOIKII	.9					
other than	So	12			Hous	sewife	1			Domes				
be file tal Hyy dothe	B	17. Father's Name (First, Middle, Last)							(First, Middle, 1 M. Hei	Maiden Suman	10)			
Maryland d 2 should be f th end Mental H 7 is merked of traumetic eve	٥													
Ma d 2 st d and d b end f i end treur		19a. Informent's Name/Relationship (T							elle, N	r, City or Town, V 10801	State, Zip	Code)		
C Z O L		20a. Method of Disposition	11/Daugite	20b. Place	of Disposi	ition (Name o	f	VIOCIA	Date		City or To	own State		
		1 ☐ Burlal 2 🎖 Cremation 3 ☐	Removel from State			atory or other		6/	Date 20c. Location - City or Town, State 6/15/99 Salisbury, MD					
₩ 58€		4 Donation 5 Other (Specify		Salis	22	Cremat	Idrage of Egoi	lite						
Ba Deprime	9000	1000	0/2	20 3	H	olloway	y Funer	cal Ho					ation	
		Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804  Sal Part. Enter the disease, or complications that caused the both. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate												
Physicia		shock, or heart failure. List only o	ne cause on each lin	7	5 1101 011101	1 110 111000 01	dynig, oddir di	o ourdido or	rospilatory an	1001,		Interval E Onset ar	Between	
/Medica		Immediete Cause (Final	CODONAD	v anmo	DV D7	CDACD								
Examine	er	disease or condition resulting in deeth)	a. CORONAR	Y ARTE		- 177								
	je je		ARTERIO				ASCULA	R DIS	EASE		1			
. Box 68760, death certificate be executed e ettending physician and ed for use as the buriel-transit	Examiner	Sequentially list conditions.	D	Due to (or as		1					1			
ian a											i			
68760, flicete be ex physician as the burie	Medical	that Initiated events resulting in death) Lest	c	Due to (or as a	conseque	ence of):								
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Box eath cert ettending for use	Jan		d											
of the desire teched f	Physician/	Part II. Other significant conditions co	ntributing to death bu	it not resulting	In the und	derlying cause	given in Part	t.	23b. Dld t	obacco use co	ntribute t	the caus	e of death?	
- a - a									101	res 2□ No	3 Pro	bably 4	Unknow	
0 2 52	d b								24a. Was	an autoney	24h W	ere auton	sy findings	
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50	ပိ									es 2 X No	t [	☐Yes 2	No No	
of Vital Physician: This certificater al director, pa	00	examiner?	Hospital:		Dutpetient	- T DO.	Other		(Check only o		40			
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Division  To the Hospital or Attending within 24 hours efter deeth.  To the Funeral Director: After completely filled in by the fune	ertification:	2   Sulcide   6   Could not be determined   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or City or Town, State)									per or Rura	al Route N	umber,	
Diving our or	O													
Hospital     24 hours     Funeral     Netely filled	edical	29a. Certifier 1 ☐ Certifying Phy (Check only one) 2 ☑ Medical Exam	sician: To the best o ner: On the basis of and manner sta	examination a	ge, death o ind/or inve	occurred at the estigation, in r	e time, date a ny opinion, de	nd ptace, a ath occurre	nd due to the o	cause(s) and made,	anner as a and due to	tated. o the caus	e(s)	
To the To the comple	Me	29b. Signature and title of certifier				29c. Lic	ense number			29d. Date signe	d (Month,	Day, Year	-)	
	D.M.E. D0003599 06-14-99													
		30. Napre and address of person who c	ompleted cause of de											
3		JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY MD 21801												

State Registrar Registrar's Signature & Sparks

DHMH 16 Rev 6/95

EDEL A TABLE

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State of Maryland / Department of Health and Mental Hygiene

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		Certificate	of Death	R	eg. No.	to I had to
	Decedent's Name (First, Middle, Last)			2. Dete of Deet		3. Time of Deeth
Physician	ROBERT M.	POMORY		JUNE.	Dey Yeer 18 1999	2:25P1
/Medical examiner	Fecility Neme (# not institution, give street end number)		4b. City, Town, or L		4c. County of Dee	th
Adminici	North Arundel Hospital		61en Bul	nie.	Anne A	rundel
eral	Sociel Security Number 6. Sex 7. Age (In yr		Year   If Under 24 Hrs.	8. Date of Birth (Month, Dey,		thplace (State or Foreign ountry)
ctor	14-38-1527 12XM 2□F 59		Deys Hours Min.	JUNE 11	,1940 MAR	YLAND
		City, Town or Location				10d. Inside City Limits
Director	ARYLAND ANNE ARUNDEL L	INTHICUM				1 ☐ Yes 2 X No
i i	De. Street and Number	10f. Zip C	ode	1	0g. Citizen of Whet Co	ountry?
	720 EAST MAPLE ROAD	210	90		U.S.A.	
iner must	Meritel Stetus     12. Wes Decedent Ever in Armed Forces?	U,S. 13. Wes Decede	nt of Hispenic Origin? (Sp y Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Bleck, Whi	
by Fu	1 Never Married 2 Married  1 Yes 2 No If Yes, Give Yeer or Detes:	1 ☐ Yes 21		, , , , , , , , , , , , , , , , , , , ,		HITE
	15. Decadent's Education	16e. Decedent's Usuel	Occupation		16b. Kind of Business	/Industry
9	(Specify only highest grade completed)  Elementery/Secondary (0-12) College (1-4or 5+)	life. DO NOT use	done during most of work retired)	king		
Completed	12	PRESIDEN	T		THEATER	
Be C	7. Father's Neme (First, Middle, Last)		18. Mother's Nam	e (First, Middle, I	Maiden Sumame)	
0	LOUIS C. PO	OMORY	EMMA		P. BE	NSON
-	9e. Informent's Name/Relationship (Type, Print)	19b. Meiling Address /	Street and Number or Ru			
	DONALD J. BENSON, SRBROTH					
		. Plece of Disposition (Neme			20c. Location - City or	
	1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State	cemetery, cremetory or oth	er plece)	une 23.		
		HESAPEAKE CRE			STEVENSVIL	-
80	Signature of Funeral Service Licensee		Address of Fecility SI			
20	A Motor	1 SECON	D AVE. S.W.	, GLEN B	URNIE, MD	21061
	23a. Pert1. Enter the diseese, or complications thet caused the deshock, or heart failure. List only one cause on each line.	eeth. Do not enter the mode	of dying, such es cardiac	or respiretory err	est,	Approximete
n	snock, or neert failure. List only one cause on each line.					Onset end Death
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À	to going arrang	war.				
eleted by P	0			24a. Was a perfor		Were eutopsy findings evelleble prior to
Completed				Political		completion of cause of death?
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Ö	K Was one referred to the direct					1,001,180
Be	5. Was case referred to medical examiner? Hospital:		Other	th (Check only or	A commence conserva-	174.4
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E	4 Homicide determined 28e. Place of Injury - At building, etc. (Spe	t home, farm, street, factory, cify)	office	City or Tow	treet and Number or F n, State)	tural Proute Petimoler,
S						
	9a. Certifier (Check only 2 ☐ Madical Examiner; On the basis of exami	nowledge, death occurred el	the time, dete end plece	, end due to the c	euse(s) and menner e	s stated.
edicai	one) and manner stated.	metion entrol investigation, i	Tilly opinion, death occu	ined et the time, o	ete ena piece, ena de	0 10 1/10 00000(0)
Σ	9b. Signatory and title of conflier	29c.	License number	2	19d. Date of med (Mon	Day, Year)
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	Jorge M. Ramirez, M.D. 784		d, Suite 20	o, Gren	burnie, Ma	ryland 2
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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death Month Per Year

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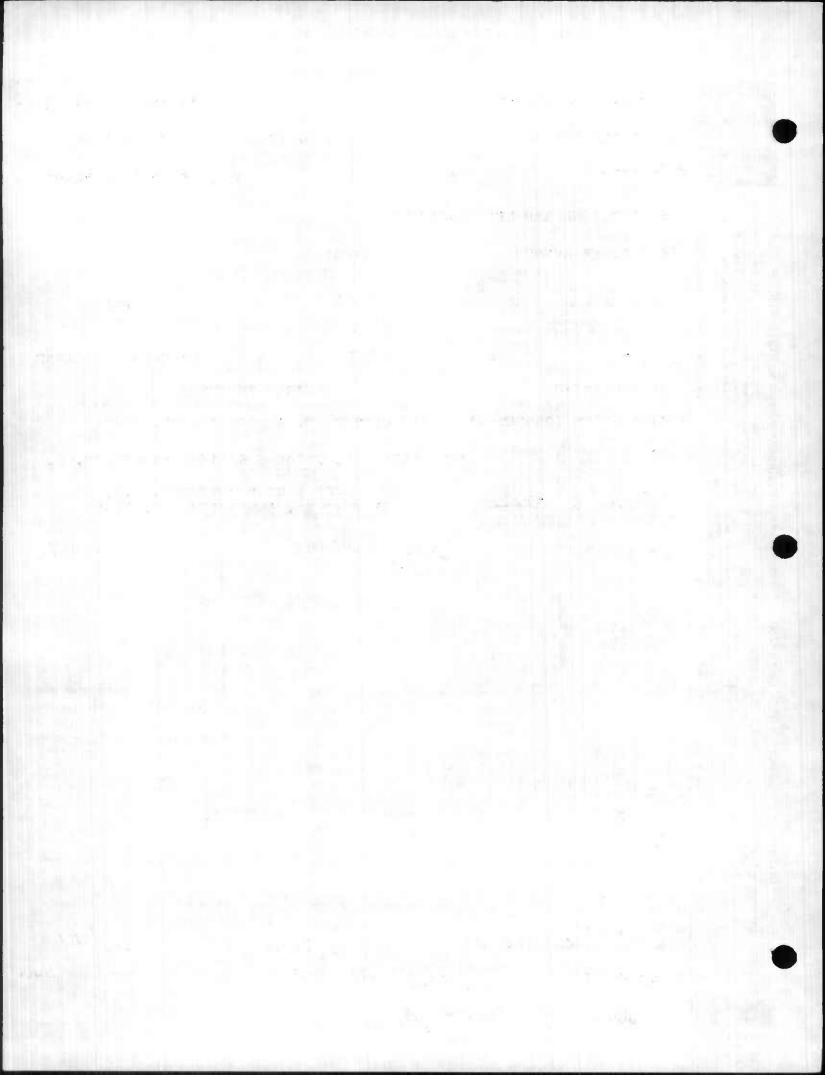
Judy Howing

Milt 888 Some & London

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State of Maryland / Department of Health and Mental Hygiene 9 9 2 2 5

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tha tha	1 Neturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not determine	be 28e. Pleca of I	njury - At home		М	1 🗆	Yes 2	No	28f. Location City or To	(Street end Nur own, Stele)	3. Time of Death 11:45 p 4c. County of Deeth ANNE ARUNDEL 9. Birthplace (State or Foreign Country) 19:38 MARYLAND 10d. Inside City Limit 11/2 Yes 2 No. Citizen of Whet Country? US 14. Race - American Indien, Bleck, White, etc. Specify: BLACK b. Kind of Business/Industry  TERGATE VILLAGE iden Sumeme)  City or Town, State, Zip Code) MD . 21401 c. Location - City or Town, State ANNAPOLIS, MD .  RY, P.A. MD . 21401 c. Location - City or Town, State ANNAPOLIS, MD .  RY, P.A. MD . 21401 c. Location - City or Town, State ANNAPOLIS, MD .  RY, P.A. MD . 21401 c. Location - City or Town, State ANNAPOLIS, MD .  RY, P.A. MD . 21401 c. Location - City or Town, State ANNAPOLIS, MD .  RY, P.A. MD . 21401 c. Location - City or Town, State ANNAPOLIS, MD .  RY, P.A. MD . 21401 c. Location - City or Town, State ANNAPOLIS, MD .  RY, P.A. MD . 21401 c. Location - City or Town, State ANNAPOLIS, MD .  RY, P.A.  Injury occurred  Secondary of Country  1 Yes 2 No			
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To the comple	29b. Signeture and title or certifier	wills	40		29	c. Licens	se number	38		29d. Dete sig	ned (Month,	Day, Year	7	
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State	31. Dete filed (Month, Day, Year)		strer's Signature	2	A	2		_		334				



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Hazel E. Rash 4c. County of Death JUN2 0042 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) Examiner WICOMICO SALISBURY PENINSULA REGIONAL MEDICAL CENTER If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M 2 F Days 75 218-16-9140 Director 9-16-1923 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County itism 27 le marked other than "natural", or flema 23a or 28a-f ehow other traumatic avent, the Medical Examiner must be not field at 1 ☐ Yes 2 No Delmar Director Sussex 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 19940 RFD#2 Box 24 Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 12. Wes Decedent Ever In U.S. Armed Forces? 11. Maritel Stetus 1 ☐ Yes 2 ☐XNo If Yes, Give Yeer or Dates: 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: þ Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Lingortant of Health end Mental Hygiene. Important: If Itam 27 is marked other than any Injury or other traumatic averaged. Elementery/Secondary (0-12) College (1-4or 5+) Homemaker 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Thomas J. Elliott Bivian Foskey 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RFD#2 Box 23 Delmar, De. 19940 John T. Rash, Son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removai from State 4 ☐ Donation 5 ☐ Other (Specify) 6-18-99 Delmar, De. St. Stephens Cemetery 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Short Funeral Home, Inc. llism N 13 E. Grove St. Delmar, De. 19940 23a. Part 1. Enter the disease, or complications that brused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause providing. Approximete Interval Between Onset end Deeth **Physician** /Medicai Immediate Ceuse (Final disease or condition resulting In death) Examiner Due to (or as e consequence of): Physician/Medical Examiner ettending physician and for use as the bunal-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events Due to (or as a consequence of) Due to (or es e consequence of): resulting in death) Last 88 ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 760217 þ 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 28. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 2 Ho 1 Depatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how Injury occurred I Director: After the Certification: 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 -Natural 1 TYes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Certifier

The law requires that the death certificate be executed Box 68760 Division of Vital Records, P.O. Physician: or Attending To the Hospital

signed by

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certificate

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within 24 hours after death. To the Funeral Director: Al

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hours efter

Pages 1 and 2 should be filled within 72

Maryland 21215-0020

Registra

(Check only one)

30. Neme

29b. Signature and title of cortifier

address of person who completed cause of death (item 23a) (Type, Print) ockes 31. Date filed (Month, Day, Year)

JUN 1 6 1999

100 32. Registrar's Signature

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29d. Date signed (Month, Dey, Year)

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**Funeral** 

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Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Day 0853 AM Physician JUNE 22, 1999 Carolyn Yerkes Spalding /Medical 4c. County of Death 4s Fscility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ROUTE 50 AT ROUTE 301 COLLEGE PARK PRINCE GEORGES If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplaca (Stata or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Months Hours 1□M XXF 571-18-4793 20,1915 Washington, D.C. Usual Residence of Deceden 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 XNo Directo Maryland Anne Arundel Annapolis 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1201 Eden Lane United States

14. Race - American Indian,
Bleck, White, etc. 21403 Funeral Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: white Specify: þ 3 Ø Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) +6 Translator Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arnold P. Yerkes Rebecca Moon 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia PIllman (Niece) 1414 H West Wrightwood, Chicago, Illinois 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Ft. Lincoln Crematory 4 ☐ Donation 5 ☐ Other (Specify) 6/25/99 Brentwood, Maryland 22. Nama and Addrass of Facility John M. Taylor Funeral Home, Inc. 21. Signatura of Funaral Sarvice Licenses 147 Duke of Gloucester St. Annapolis, MD 21401 m. Les 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Betwe Onset and Death Immediate Cause (Final Injuries disease or condition resulting in death) Due to (of es e consequence ot): Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequenca of) Dua to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 54 Inknown

**Physician** /Medical Examiner

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page 2

funeral director,

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Medical

certificate

After this

after death.

within 24 hours a To the Funeral D Hospital

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The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vitai Records.

or Attending Physician:

Examine Physician/Medical Completed by Be Certification: To

24a. Was an autopsy performed? 26. Place of Deeth (Check only one)

24b. Were autopsy tindings avsitable prior to complation of cause of death? ₩ Yes 2 No

25. Wes case reterred to medical examiner? 12 Yes 2□ No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work?

Other: 4 Nursing Home 5 Residenca (Specify) 28d. Describe how injury occurred motor Vehicle Collision

1 Yes

2 No

5 Pending Investigation 1 Netural 6/22/99 8391 2 / Accident 8 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide

West rs

1 Yes 2 No spreu

281. Location (Street and Number or Rural Routa Number, City or Jown, State) U.S.R.f. 50 2. U.S.R.f. 30 | Calley 10 1 2-

29e. Certifier (Check only one)

27. Menner of Death

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signstura and Aitla of certifier

31. Date filed (Month, Day, Year)

29c. License number O.C.M.E.

29d. Data signed (Month, Day, Year) JUNE 23, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nnis

hute M111 Penn Street, Baltimore, Maryland 21201

State Registrar

JUN 2 5 1999

32. Registrar's Signatura

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 2 2 3

Debug of Death   Physician
EVELVN SHAW
Frammer  Function  Functio
ANNE ARUNDEL  Social Social Social Number  1
Director    214-24-7539
Director    214-24-7539   10. Certy   10.
Usual Residence of Decedent   10c. Caty, Town or Location   10d. Inside   10c. State   10c. St
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Elementery/Secondary (0-12)   College (1-4or 5+)   HOUSEKEEPER   NORMAN HAZARD
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27. Manner of Death 1 Sulatural 2   Accident 3   Suicide 4   Homicide 28a. Date of Injury 28b. Time of Injury 4   Work? 1   Yes 2   No 28b. Time of Injury at Work? 1   Yes 2   No 28c. Injury at Work? 1   Yes 2   No 28d. Describe how injury occurred
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and menner steted.  29c. License number  29d. Dete signed (Month, Day, Year)
29b. Signeflure end title of certifier  29c. License number  29d. Dete signed (Month, Day, Year
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)  Way no Bierbaum 134 avensuit Road, West Aver, My
30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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State of Maryland / Department of Health and Me

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N	Examiner	4a Facility Name (If not institution, g	rive street and number)						ocation of Death	, , , , , , , , , , , , , , , , , , , ,			
		Future-Care C					Arn					undel	
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	2 * 2	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lir											
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020	ours after death raif, or flems 23 Examiner, must by Furneral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent   Armed Forces? 1 Yes 2   If Yes, Give Year or Dates:	Ever in U,S. No		as Decedent Yes, specify (			ecify Yes or No- Rican, etc.)	Bia	e - American ck, White, et ::Whit	c.	
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Maryland 21215-0020	Abental H Asset off ficewer	17. Father's Name (First, Middle, La Chris Nelson	st)						e (First, Middle, 1 sta Her		10)		
Man	alth and 2 27 is ma r trauma	19a. Informant's Name/Relationship Nelson Tyding		196	. Mailing	Address (St. Beechv	reet and Numb 100d R	d. I	al Route Number Arnold,	MD 2	State, Zip 0	ode)	
<b>Baltimore</b> ,	Pages 1 a nerit of He ant: If Rem ary or othe	20a. Method of Disposition  1  Burial 2  Kernation 3  4  Donation 5 Other (Special Control of the Control of th		20b. Place of comete.	ry, cremi	atory or other	f place)		Date 5/24/99	20c. Location - Brei		n, State	
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Records,	The law requires that the de rate has been signed by the opege 2 should be detached Completed by Physic		(						24a. Was a perform		avai	e autopsy findings lable prior to pletion of cause	
360	8 K D											eath?	
=	icata h								1 🗆 Yı	1	10	Yes 2□ No	
Vital	Physician: The in this certificate he rai director, page rai director, Dege Com.; To Be Com.	25. Was case referred to medical examiner?	Hospital:	-5			Other /		h (Check only on				
Share .	Physic rai din	1 Yes 2 No 27. Manner of Death	1 LI Inpatie	20 11 11 11 11	rtpatient		402 N	ursing Ho	ome 5 Reside				
5	After fune	1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	njury		Injury at Work? 1 ☐ Yes 2 ☐	1 No	200. 0000100 11	ow injury occur	100		
Division	tal or Attending P rs after death. si Director: After ti ed in by the funera Certification:	3 Suicide 6 Could not	be on Division	ırv - At home, fa	rm. stre				28f. Location (Si	reet and Numl	per or Rural	Route Number.	
<u>}</u>	after Direction of A	4 Homicide determine	building, etc	. (Specify)	, 500	ot, 140tory, 011			City or Town				
	al C	29a. Certifier 12 Certifying I	Physician: To the best of	of my knowledge	, death	occurred at th	e time, date a	nd place,	and due to the co	euse(s) and m	anner as sta	ted.	
	n 24 hound	(Check only 2 Medical Excone)	aminer: On the basis of	examination an	d/or inve	estigation, in r	ny opinion, de	ath occur	red at the time, d	ate and place,	and due to t	he cause(s)	
	To the Hospital or Attending Phyminia & house the death.  To the Funeral Director, After this completely filled in by the funeral completely filled in by the funeral Medical Certification:	200. Signature and the of configer	11/10	A		29c. Lic	cense number	-	2	9d-Pate signe	d (Month, D	ay, Year)	
	(	AM WX	og w	Jny		D	214	38		you	e V	47	
		30 Name and address of partion wh	completed bause of de	eath (Item 23a)	(Туруі, Р	(An) (1)	7. 4	11	(15-12-	JAN AN	MAMO.	a Mal	
		31. Date filed (Month, Day, Year)	- La rewro	m's Signature	UY	CUG	EYN	VE:	>16/1	100	10109	240/	
	State	ITTAL 9 A	1000	- Congression	4	1							

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene AMEND # 26, 28D 6/24/99 CMH AACO HEALT Dertificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 1999 12 **Physician** Charles William Wietscher, Jr. June 4:15 AM · /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner 303 McDonough Rd. Anne Arundel Annapolis Hours Min. 8. Date of Birth (Month, Day, Year)
July 23,1924 If Under 1 Year Birthplece (State or Foreign Country)
 Maryland. 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Deys 1 X M 2 □ F 212-20-4662 74 Yrs Director Usual Residence of Decedent with the Meryland 10e. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f ahow the Medical Examinar must be notified at 1 Yes 2 No Director Anne Arundel Annapolis 10g. Citizen of Whet Country? 10e. Street and Number 10f, Zip Code 303 McDonough Rd. 21401 USA Funeral filed within 72 hours efter deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 No 1942 to 14 Yes, Give Yeer or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Merried 2 ☑ Married 1945¹□ Yes 2⊠ No altimore, Maryland 21215-0020 p 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind ot Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed will Department of Heelth and Mentel Hygien Important: If Item 27 is marked other that any fulury or other traumatic event, the bonds. Rate Manager Railroad 4 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Charles William Wietscher, Sr. Edith Simms 19a. Interment's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Lydia Wietscher / wife 303 McDonough Rd. Annapolis, Md. 21401 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method ot Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal trom State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 6-13-99 Brentwood Md. 22. Name end Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Servica Licensi 147 Duke of Gloucester St. Annapolis, MD21401 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Due to (or as e consequence ot) Examine dio mosat ician end buriel-trensit certificate be executed Sequentielly list conditions, if any, teeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Myocardial Division of Vital Records, P.O. Box 68760, physician 940 2 Physician 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No signed t þ 24b. Were eutopsy tindings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? certificate has b irector, page 2 s 2/1 No 1 Yes 1 ☐ Yes 2 ☐ No Physician: 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient → BOA 10 1 Yes 28e. Date of tnjury (Month, Dey Year) 28d. Describe how Injury occurred 27 Menner of Deeth 28b. Time of 28c. Injury at Work? Certification: Naturel 5 Pending investigation 1 TYes 2 No 2 ☐ Accident 28t. Location (Street and Number City or Town, Stete) ofter deeth Director: 6 Could not be determined 3 ☐ Suicide or Rural Route Number 28e. Place of Injury - At home, tarm, street, fectory, office building, etc. (Specify) filled in by 4 Homlcide 24 hours e Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) To the Vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 9 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 2003 Medical Parkway Annapolis, MD 21401 James W. Ross. M.D. 31. Date tiled (Month, Dey, Year) 32. Registrar's Signature B. Sparked Registrar JUN 2 4 1999

**DHMH 16 Rev 6/95** 

# Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 21, 8:50 pm June Frederick Andrew Wiseman /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Corsica Hills Nursing Home Centerville Queen Anne's Months Days Hours Min. 8. Date of Birth Month, Day, 7 Aug 27, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1☑M 2□F 77 Director Maryland 213-16-4694 Usual Residence of Deceden 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location show Queen Anne's MD Stevensville 1 ☐ Yes 2 No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 228 Bridgeview Lane 21666 USA Norms 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No if Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: White Specify TIWW à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Honeywell Maintenance Foreman d 2 should be filled w th and Mental Hygie 7 is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Joseph Andrew Wiseman Pages 1 and 2 should Dorothea Friedrich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If them 27 is any injury or other traus 228 Bridgeview Lane, Stevensville, MD 21666 Mary Alice Wiseman/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Cem. 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ★ Burial 2 Cremation 3 Removal from State June 24 Arnold, MD Asbury Methodist Church 4 ☐ Donation 5 ☐ Other (Specify) 1999 21. Signature of Furieral Service License 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD

23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Applications that caused the death. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final GM Brain Cancor disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai Due to (or as a consequence of) P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably 4 Onknown Records, þ 24b. Were autopsy findings evailable prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 2 s 1 ☐ Yes 2 BNo 1 ☐ Yes 💯 No certificate Division of Vital 25. Wes case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home' 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: or Attending 5 Pending Natural 2 Accident 1 Yes 2 No hours after death. Director: / 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by 4 Homicide edicai 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 132036 mune Ma 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2108 D. Donato Drive Charles, mo 21619 Sprint

State Registrar

31. Date filed (Month, Day, Year)

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32. Pegistrar's Signature

AND THE STATE OF T

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death **Physician** JUNE 17, 1999 WHITE 8:15 AM /Medical 4a. Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 34339 OLD OCEAN CITY RD. PITTSVILLE WICOMICO If Under 1 Year If Under 24 Hrs. 8, Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 2X F Days Yrs. Director 216-54-9234 OCT. 86 DELAWARE Usual Residence of Decedent filed within 72 hours efter death with the Maryland 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show treumstic event, the Modical Examiner mant to not fed an 14 Yes 2 □ No Director MARYLAND WICOMICO PITTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21850 U.S.A. 34339 OLD OCEAN CITY RD. Completed by Funeral 12. Was Decedent Ever In U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 Divorcad Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementery/Secondery (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) jes 1 end 2 should be fill of Health and Mental H f Item 27 is merked oth CHARLES BAKER Ε. LIZZIE BAKER H. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) GERALD R. WHITE - SON 35323 RAILROAD AVE. WILLARDS, MD other Peges 1 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō 1 Burial 2 ☐ Cremation 3 ☐ Removel from State = 6 Depertment of important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 6/21/99 PITTSVILLE, MARYLAND PITTSVILLE CEMETERY 705 E. MAIN ST. 22. Name and Address of Fecility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. SALISBURY, MD 21804 Approximete Interval Between Onset end Death **Physician** Astoniosclosofic /Medicai Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed the buriel-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last P.O. Box 68760. Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 12 No 3 Probably 4 Unknown should be det Records, Completed by 24b. Were eutopsy findings evailable prior to 24a. Was an autopsy performed? completion of cause of death? has page 2 2 No certificate Division of Vital Hospital or Attending Physicien: funeral director, 25. Wes case referred to medical examiner?
1 ✓ Yes 2 ☐ No Be 26. Place of Deeth (Check onbyone) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) Certification: To this 27. Men fer of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred After Netural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 1 🗌 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edicai 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) (Check only one) To the 29c, License number 86/4 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifier value of death (Item 23a) (Type, Print) 30. Name and address of person who completed 12 SAGGAR, MD RIVERSIDE 541D SALISBURY , MO Deepak 21801 32. Registrar's Signature 31. Dete filed (Month, Day, Year) State JUN 1 8 1999 Registrar

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in the Head Paline Agency

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dete of Death 3. Time of Death Month **Physician** June 15, 1999

4c. County of Deeth Betty WILSON 12:50 AM /Medical 4e Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death Examiner Salisbury
If Under 24 Hrs. 8. Data of Birth
(Month, Dey, Yeer) 506 C Chelsea Court Wicomico If Under 1 Year Birthpleca (State or Foraign Country) 5. Social Sacurity Number 6 Sax 7. Aga (In yrs. last birthday) **Funeral** 1□M 2⊠F Months Days Yrs. 65 Director 222-18-6348 March 11, 1934 Delaware Usual Rasidence of Decedan the Marylend 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flems 23a or 28a-4 ahow traumatic avent, the Modical Exams for maint be nothled as Maryland Wicomico 1 ☐ Yes 2€ No Salisbury Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ent of Heatin and Mental Hydiene.
Int: If time 27 is marked other than naturall, or items 23a or 2 mry or other traumatic avent, its Mancal Easter entails or into or other traumatic avent, its Mancal Easter entails or o 506C Chelsea Court 21804 USA Funeral 11. Maritel Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - American Indian Bleck, White, etc. 1 □ Navar Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: White þ 3 Widowed 4 K Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Laundry 12 Aid 18. Mother's Nema (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Rebecca H. Moore Harvey E. Coffin 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Sue E. West/Daughter 168 Dickens Court, Felton, DE 19943
of Disposition (Name of Dete 200. Location - City or Town, Stete 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 1⊠ Buriel 2 ☐ Cramation 3 ☐ Ramoval from State 6/19/99 Department of important: If any injury or Millsboro, DE 4 ☐ Donetion 5 ☐ Other (Specify) Millsboro Cemetery Neme end Address of Fecility Holloway Funeral Home Professional Association 21. Signature of Furneral Service Licenses 501 Snow Hill Rd., Salisbury, MD 21804 or complications that caused in the data. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one cause on each limit Approximete Intervel Between Onset end Deeth Physician LUNG CANCER /Medical Immediate Cause (Final diseasa or condition resulting in deeth) Examiner Examiner physician and the bunal-transit requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting In death) Last Due to (or as a consequenca of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) as use 23b. Did tobacco use contribute to the cause of death? Pert II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the should be deteched Ves 2 No 3 Probably 4 Unknown p 24b. Were eutopsy findings evailable prior to complation of cause of deeth? Completed 24e. Wes en eutopsy page 2 2 No 1 Yes 1 Yas 2 No certificate or Attanding Physician: funeral director. Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28e. Date of Injury (Month, Dey Year) 28d. Describe how Injury occurred 27. Menner of Death 28c. Injury at Work? 28b. Time of Naturel 5 Panding 1 ☐ Yes 2 ☐ No death. investigation 2 Accident ofter deatl 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours e Hospital Sertifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and menner es steted.

| Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred et the time, date end pieca, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) Medical npletely To the Vithin 2 200. Signature and title of cartified 29d. Date signed (Month, Dey, Year) and eddress of person who completed ceuse of deeth (Item 23e) (Type, Pmt) RIVERSIDE PRINC - SALISBURY MD 12 560 leury 31. Dete filed /Mon 32. Registrer's Signeture State

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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death James Clayton Byrd ITEMS: #23 PART 28A-F PER 27. Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Physician C. James JUNE 28, 1999 5:45 PM. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2208 DRUID HILL AVE. BALTIMORE Birthplace (Stata or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 10-29-63 7. Aga (In vrs. last birthday) **Funeral** Months 1₽M 2□ F 213-88-4093 Yrs. Director MD Usual Rasidance of Decedant 10a. Slata 10c. City, Town or Location 10d. Inside City Limits Herns 23s or 28s-f show the Medical Examiner must be notified at MD NA Baltimore Yas 2□No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Dir 5601 Magnolia Avenue 21215 USA Funeral Was Decedant Evar In U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. Black, Whita, atc hours after Nevar Married 2 Married 1 ☐ Yas 2 → No natural', or 1 Yas 2 No Specify: altimore, Maryland 21215-0020 Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Hygiene. NA Collega (1-4or 5+) Elementary/Secondary (0-12) Unemployed NA 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Be Peges 1 and 2 should be end Mentel le marked James A . Byrd, Hilda Hill 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) permit. Peges 1 and 2 a Department of Health or Important: If from 27 to eny Injury or other treu pace. Hilda Μ. Byrd 5601 Magnolia Avenue Baltimore, MD. 20b. Place of Disposition (Nama of cematary, crematory or other p 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata MD 1 Burial 2 □ Cremation 3 □ Ramoval from State Cedar Hill Cemetery 07-07-99 Anne Arundel Co. 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licens 22. Nama and Addrass of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Death Physician /Medical Immediata Causa (Final NARCOTIC INTOXICATION disaasa or condition rasulting in death) Examiner Dua to (or as a consequence of) that the death certificate be assecuted Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or injury that initialed evants rasulting in death) Last Dua to (or as a consequence ot): Box 68760 Physician/Medical the Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? O signed by the 1 Yes 2 No 3 Probably 4 Unknown 0 Records. λq 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 2 No 2□ No certificata of Vital Physician: director 25. Was casa ratarrad to medical Be 28. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 X Othar (Specify) XYas 2□ No Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this 28b. Time of Injury 27. Mannar of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? SCENE After 5 St Pending invastigation Division or Attending 1 Natural 6-28-99 1 Yas 2 No UNKNOWN death. UNKNOWN 2 Accidant after death Director: 6X Could not be datarmined 3 Suicida 28a. Place of Injury - At homa, tarm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number of Rural Route Number. City or Town, Stata) 2208 DRUID HILL AVE. 3 4 Homicida HOUSE BALTIMORE, MARYLAND 24 hours Hospital 29a. Certifie Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 **\$** 29c. Licensa number 29d. Data signed (Month, Day, Year) O.C.M.E. JUNE 29, 1999 tem 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Month, Day, Year) Registrar's Signatura State 0 7 1999 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dev Year **Physician** 0 ALLIE BARNES 07-2-99 0100 MAE /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) Examiner PARK ADVENTIST HOSPITAL TACOMA WASHINGTON 8. Dete of Birth (Month, Dey, Yeer) 5. 23 - 23 9. Birthplace (Stete or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 10 M 22 F Months Hours 282-24-8038 Director Usual Residence of Decedent the Maryland 10c, City, Town or Location 10d. Inside City Limits 10e. State 10b. County rsi', or items 23s or 28s-f show Examiner must be notified at 1 Yes 2 No Director MO AURE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20708 4010 BRIAR Funeral ANE deeth 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Maritei Status 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Merried 2 Married 1 Yes 2 No 1 Yes 2 No "natural", or Specify: if Yes, Give Yeer or Detes: BLACK þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life) DO NOT use retired) Completed traumetic svent, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry oe filed within 7 iel Hygiene. Elementery/Secondary (0-12) Coilege (1-4or 5+) LOTHING YR REAMSTRESS 12 TH GRADE 18, Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) h and Mentel h Pages 1 and 2 should be BROWN ABRAMS JORDAN 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Department of Health a Important: If itsm 27 is any injury or other tra BARNES BRIAR HUSBAND ROFT LAUREL, MO 20b. Piece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date 1. Burial 2 □ Cremation 3 □ Removal from State COLUMBIA 1-10-99 COLUMBIA. MEMORIAL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert failure. List only one cause on each line. 21229 Approximete Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical DIDEEMC Examiner Examiner thet the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last and physician a the burial Physician/Medical MANCE 100 Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed by þ 24b. Were autopsy findings available prior to QUE D'ESPUNCTION 24e. Was en eutopsy performed? Completed completion of cause of death? hes DRONARY ANTERY BYPASS 2 No certificata Division of Vital Physicisn: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Magner of Deeth 28c. Injury et Work? 28b. Time of After t Certification: 5 Pending investigation or Attanding n 24 hours after death.

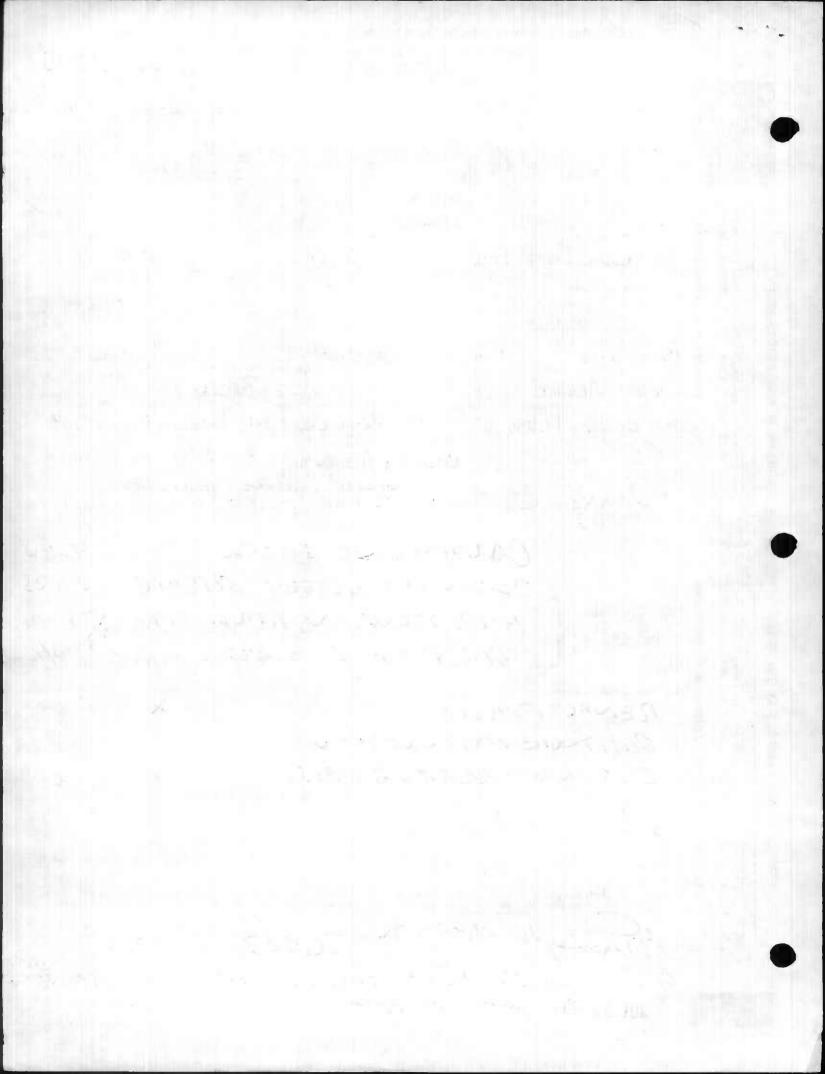
Ne Funeral Director: Al pletely filled in by the fu 1 Yes 2 No death. 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 ☐ Sulcide 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edical 29e. Certifier Descritifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner es stated. 2 Medical Examiner: On the besis of exemination end/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the cause(s) end menner stated. within 2 To the 3682229d. Date signed (Month, Day, Year) 29b. Signature end title of certifier Africian 2

, 2415 KURGEOVE RD. 07-7, SILL

State Registrar 30. Name end eddress of person who completed cause of death (item 23e) (Type, Print)

22 Bagietrar's Signature

7 1999



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician 19ENIA 3, 999 July 11:11AM /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County Examiner HUP KINS 5 HOSPITAL 7. Aga (In yrs. last birthday) Date of Birth (Month, Day, Year) OhNS 64 Sex If Under 1 Yea **Funeral** Hours Min Months Days 10M 20F Director **Usual Residence** 10n. State 10b. Count 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours efter death with the Meryler Department of Heelth and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other treumsite event, the Medical Example miss be notified. 1 Ves 2 No Funeral Director 10e. Street and Number 10f. Zip Cpde 10g. Citizen of What Country? 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 10 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status Black, White /etc 2 Married 1 Never Married 1□ Yes 2□ No Specify 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working (life, DD NOT use repred) | The control of t 15. Decedent's Education (Specify only highest grade comp 16b. Kind of Business/Industry 90000 (1-4or 5+) Elementary/Secondary (0-12) 17. Eather's Narrie (First, Middle, Last) 8 2 MAdeur 20a. Method of Disposition 20b. Place of Disposition (N 1 Suriat 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) m of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresphace, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examine ARDIOPUL MONARY the ettending physician end thed for use as the buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? deteched been signed by should be detect 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 9 Dage 2 2 NO certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) 8 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 5 1 Inpatient 2 ER/Outpatient 3 DOA 양 funeral 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? within 24 hours effer deeth. To the Funeral Director: After Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 4 Homicide

State

edical

29a. Certifier (Check only one)

29b. Signature and the

The lew requires that the death certificate be executed

Box 68760.

Division of Vital Records, P.O.

the Hospital or Attending

the Menyland

Saitimore, Maryland 21215-0020

29d. Date signed (Month, Day, Year)

m 23a) (Type, Print) 30. Name and address of person who completed cause of death

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nination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s)

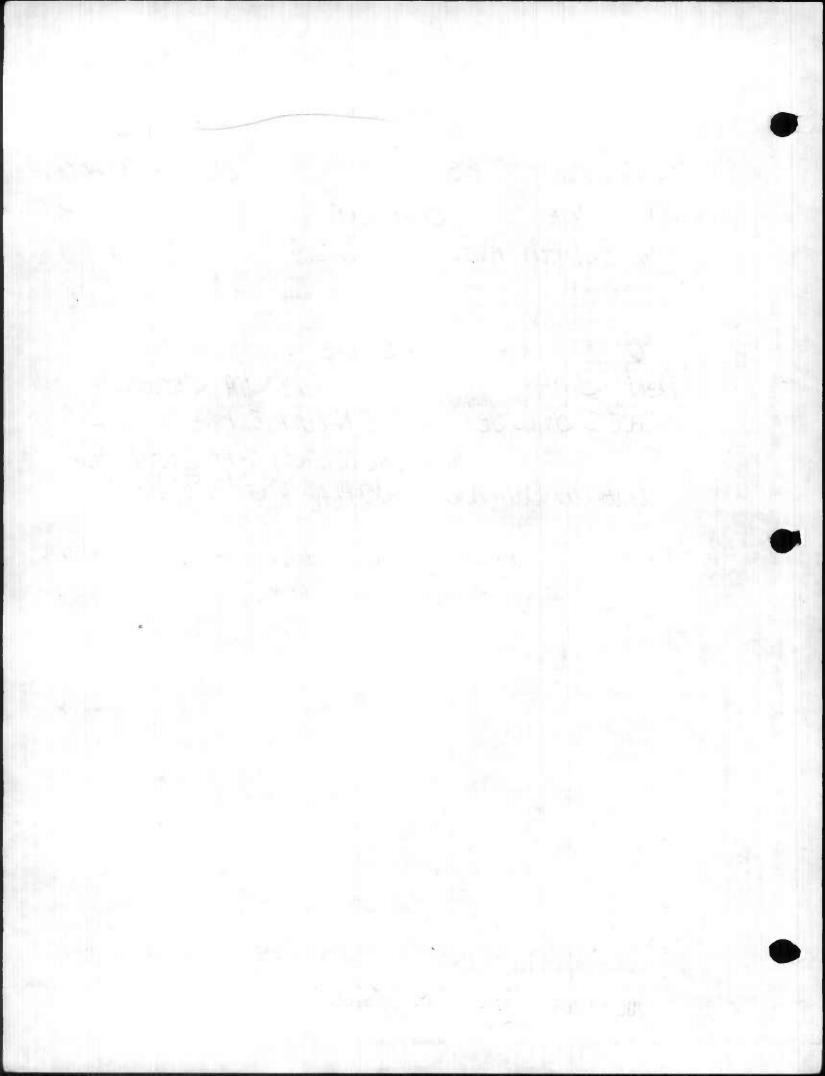
**DHMH 16 Rev 6/95** 

Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

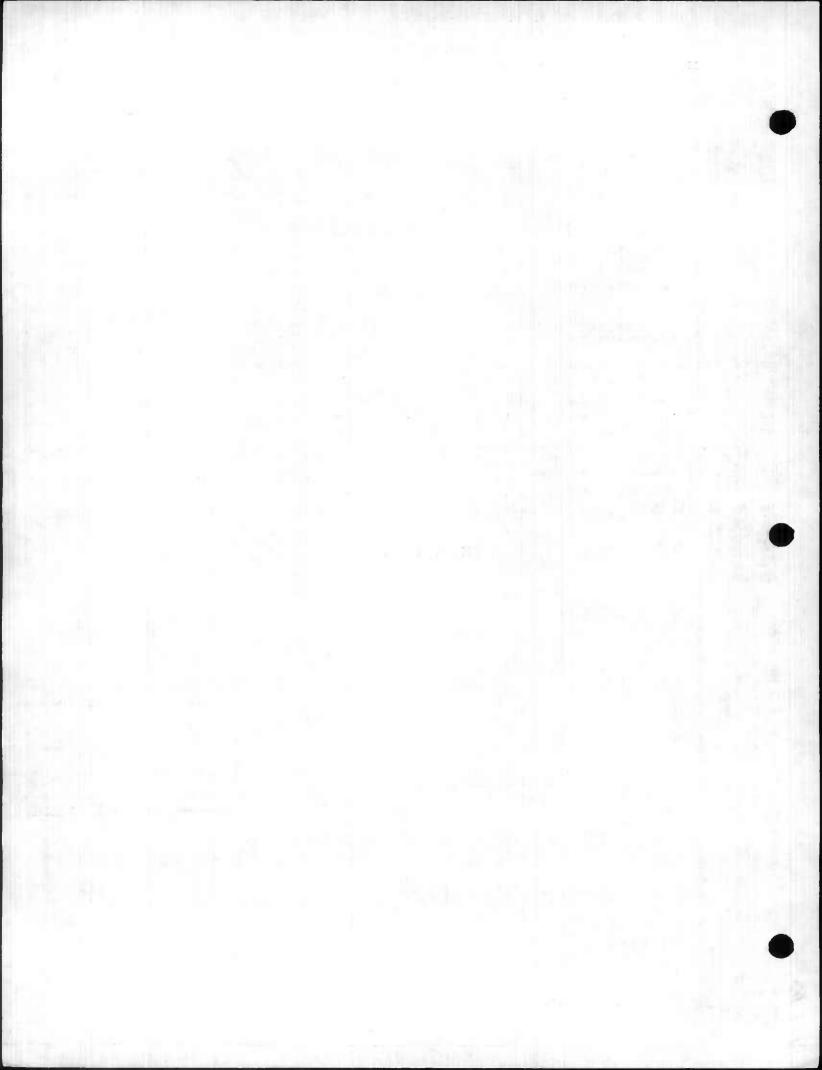
Medical Examiner: On the pasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number



AMEND#23a & 27 PER MEO G774 8-25-99 J.A.

99-3862-003



AMEND ITEM:	#20B PER F.H. G773 7-7-		Certific			R	eg. No.	212	238
Physician /Medical	1. Decedent's Name (First, Middle, Last Clara Beatrice	Bradburn			4. On T	2. Deta of Dea Month July 5	Dey 1999	Year 9	ima of Death 0:00 A.M
Examiner	4a Fecility Name (If not institution, give 220 Washburn Ave				6b. City, Town, or Lo Baltimo		4c. County o	/A	
Funeral Director	5. Social Security Number 6. Se 220–22–3981		Mon	nder 1 Year ths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Oct. 18	Year)		Stete or Foreign
death with the Meryland ms 23a or 28s-f show rmant to notified at	Usuel Residence of Decedent  10a. State 10b. County  Md. N/A  10e. Street and Number		ty, Town or Location  Baltimore	. Zip Code		1	0g. Citizen of W	1)(	side City Limits Yes 2 No
2 8 8 E	220 Washburn Aven 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	UE  12. Was Decedent Evar in U Armed Forces?  1  Yes, Give Year or Dates:		212 ecedent of H specify Cube as 2 (No	225 lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		A American fnd , White, etc. Whit	
15- n 72	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 11th		life. DO NO	Usual Occup f work done of use retired ry Pac	during most of work d)		16b. Kind of Bus Carr Lov Glass Co Maiden Sumeme	iness/Industry Wery Ompany	
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other trans	Vernon M. Bradbur	206. F	220 Was	(Name of	Avenue Ba	Date	e, Maryla 20c. Location - C		
Baitimore, Maryland 212: permit. Pages 1 and 2 should be filed within popartment of Health and Mentel Hyglene. Important: if item 27 is marked other than any injury or other traumetic avant, the solice. To Be Comp	1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funaral Service Licens	Mea	dowridge	Memor					ind
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The law requires that the has been signed to page 2 should be det			-	ď		24a. Wes a perfor	med?	available	on of cause?
On of Vita Ing Physician: After this certific funeral director.	27. Manner Death  1 Matural 5 Pending investigation  2 Accident investigation  3 Suicida 6 Could not be	28e. Date of fnjury (Month, Day Year)	28b. Time of fnjury		y at k? Yes 2 No	th (Check only or me 5 P Residence 28d. Describe h		r (Specify) id	
DIVISIC  To the Hospital or Attance within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificat	4   Hornicide	4 Homicide determined 256. Place of Injury - At nome, farm, street, factory, onice building, etc. (Specify)							a rearribor,
To the Hospital Within 24 hours To the Funeral completely filled Medical C		ner: On the basis of examine and manner stated.	ition and/or investiga	29c. Licens	pinion, death occur	red at the time, d	late end plece, a	nd due to the c	
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State Registrar	30. Name and address of person who co	mpleted cause of death (Item  ### 1600    32. Registrar's Signal	Crair	Im	y, Gle	n bu	mie,	MD. 2	1061

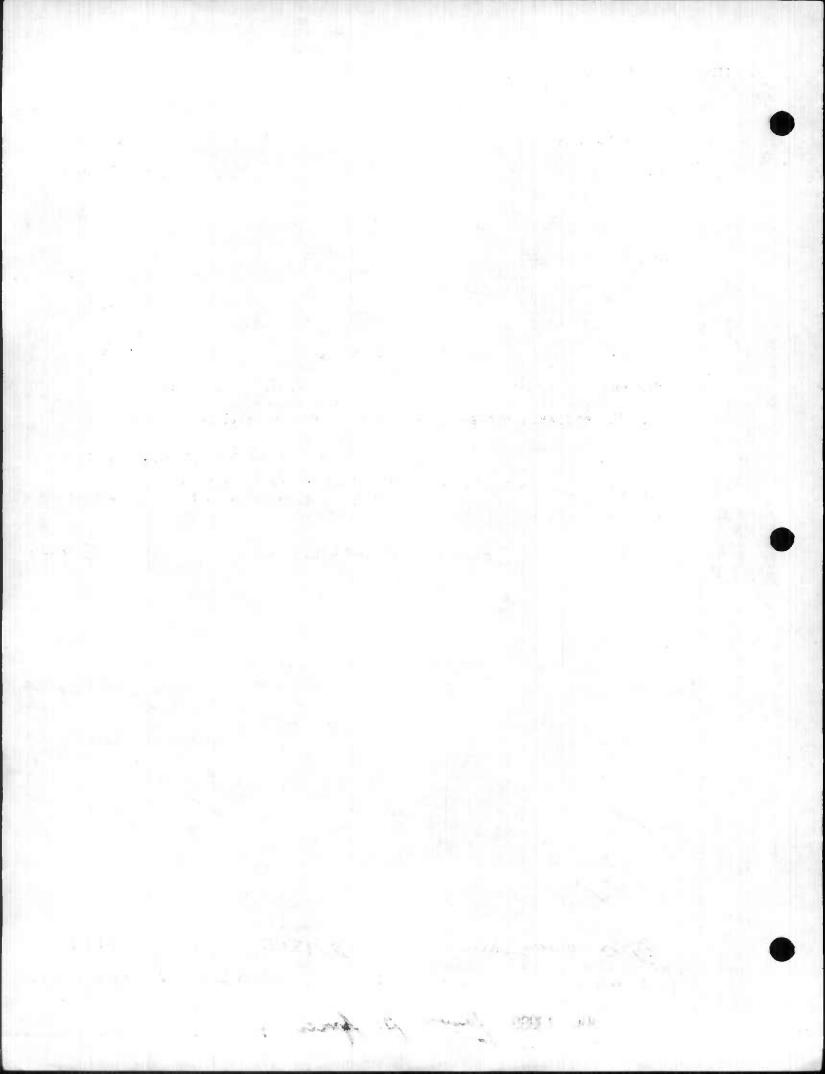
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Registrar

DHMH 16 Rev 6/95

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ORIGINAL



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Day WARREN 1999 THOMAS BANKS -IUL 22=08 H1 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death 7. Aga (In yrs. last birthday) H Undar 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 25, 1920 HARFORD ER FALLSTON GENERAL HOSPITAL 5. Social Security Number 9. Birthplaca (Stata or Foreign Country) ILLUNOIS 1 M 2□ F 359-07-4755 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Illinois Cook Chicago 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 3707 North Nordica Avenue 60634 U.S.A. 12. Was Decedenf Evar in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Datas: WW II Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Nevar Marriad 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Elementary/Secondary (0-12) College (1-4or 5+) Machine Shop Foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Orletta Warren Banks Hanson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Charlotte T. Banks (wife) 3707 North Nordica Ave., Chicago, Illinois 60634 20b. Place of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cramation 3 Removal from State 7/6/99 Baltimore, Maryland Green Mount Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, 610 W. MacPhail Road, Bel Air, MD 21. Signature of Funeral Service Licensee Inc. 21014 Mars T. 3 comblications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, 23a. Part 1. Enter the disease, or shock, or heart failure. List Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SCVD Due to (or as a consequence of) Sequentially list conditions, if any, leading to Immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown COPD 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 SER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred

Division of Vital Records, P.O. Box 68760, 8 100 987 Banks, Walkers à **page 2** oerfilicate ä

after death Director: à Hospital 24 hours

**Physician** 

/Medical

Examiner

Directo

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**Funeral** 

Director

other than "natural", or itema 23a or vent, the Medical Examiner must be r

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 Ie marked other than "natural", or Itema 23a any Injury or other traumatic event, tra Mexical Examples

**Physician** 

/Medical

Examiner

Examiner

Physician/Medicai

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Certification:

Medical

Baltimore, Maryland 21215-0020

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Registrar

Part II. Other significant conditions contributing to death but not resulting in the undarlying causa givan in Part I. 25. Was cese referred to medical examiner? 1 Yes 2 No 27. Manner of Deeth 5 Pending investigation 1 Natural 1 TYes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) 29c. Licansa number 29b. Signature and fittle of certifian 29d. Date signed (Month, Day, Year)

OCME

30, Name and address of person who completed cause of death (Item 23a) (Type, Print) PNASHU MID ZIB FULFOND AUE

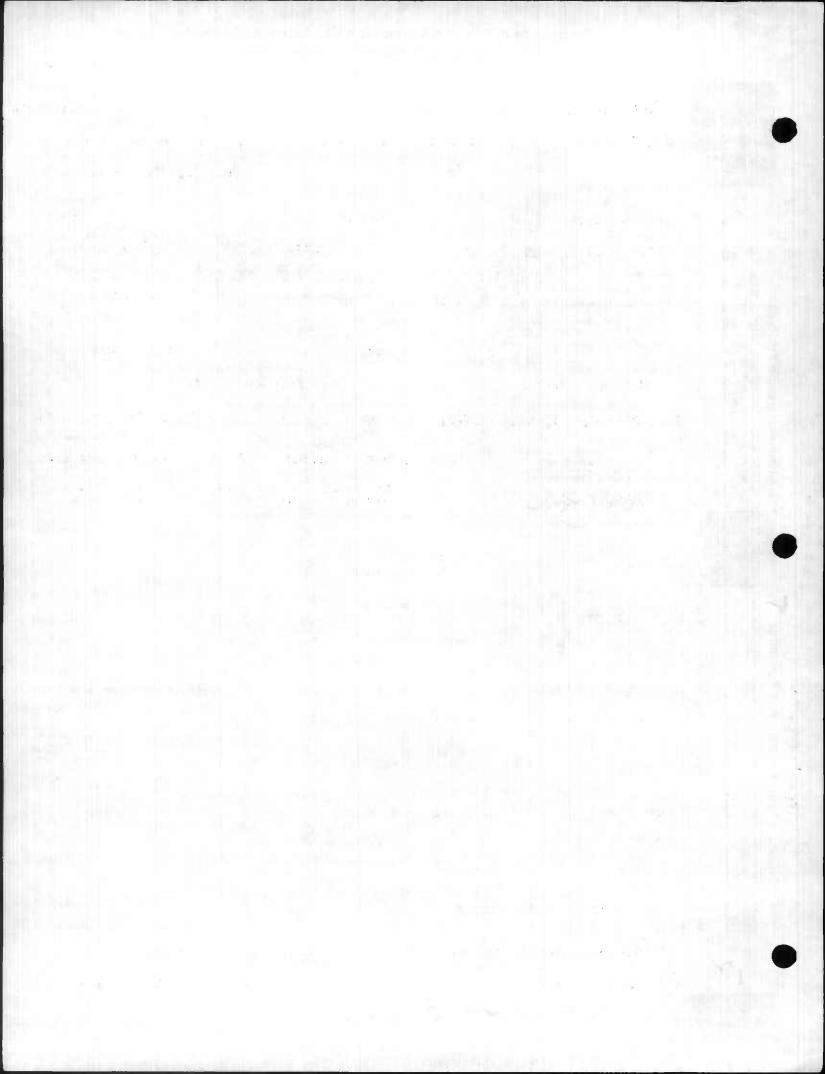
BELAIR MD 21014.

PIUL

31. Date filed (Month, Day, Year) 071999 JUL

32. Registrar's Signature

DME



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Amended Item#9 perFH, #26 perPhyG773 7/7/99 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1118 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deaft Medical Baltimor If Under 24 Hrs. If Under 1 Yeer 9. Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Dete of Birth (Month, Day, Year) 10 M 20 F 220-18-8863 Days Hours Yrs. Usual Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 No 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 50 12. Was Deceden Ever in U.S. Armed Forces 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 1t. Meritel Stetus Black, White, etc. 1 Never Married 2 Merried 1□Yes ÀV No If Yes, Give /\ Year or Detes: Specify Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Supervisor Naval Kesearch Lab 2th grade 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Neme/Reletionship (Type, Print) Rudolph Road 502 Grantley Baltimore, mg 21215 Johnson-Son 20b. Plece of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 7/6/99 National Mem. Park 4 ☐ Donetion 5 ☐ Other (Specify) Ma Naurel march Funeral, Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4300 Wabash Avenue Z3a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of) Due to (or as a consequence of):

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed will Department of Heelth and Mental Hygient Important: if item 27 Is marked other that any Injury or other traumatic avant, if ma.)

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be 0

**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f show traumstic avant, the Madical Examinar must be notified at

"natural", or items 23a

filed within 72 hours after Hygiene.

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

the Menyland

Examiner physician and the burial-transit Physician/Medical 88 Completed Be 0

signed by t peen this n 24 hours after death.

Ne Funeral Director: After the pletely filled in by the funeral or Attending To the Hospital ompletely vithin 2

	10	)
1		

23b. Did tobacco use contributa to the causa of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yas 2 200 by 24a. Wes an autopsy performed? 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 32 Hesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: Netural 5 Pending investigation 1 TYes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of tnjury - At home, term, street, tectory, office building, etc. (Specify) 4 ☐ Homicide 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

(Check only one) 2 Madtcal Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menger stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certified

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

32. Registrar's Signeture

31. Date filed (Month, Day, Year)

JUL

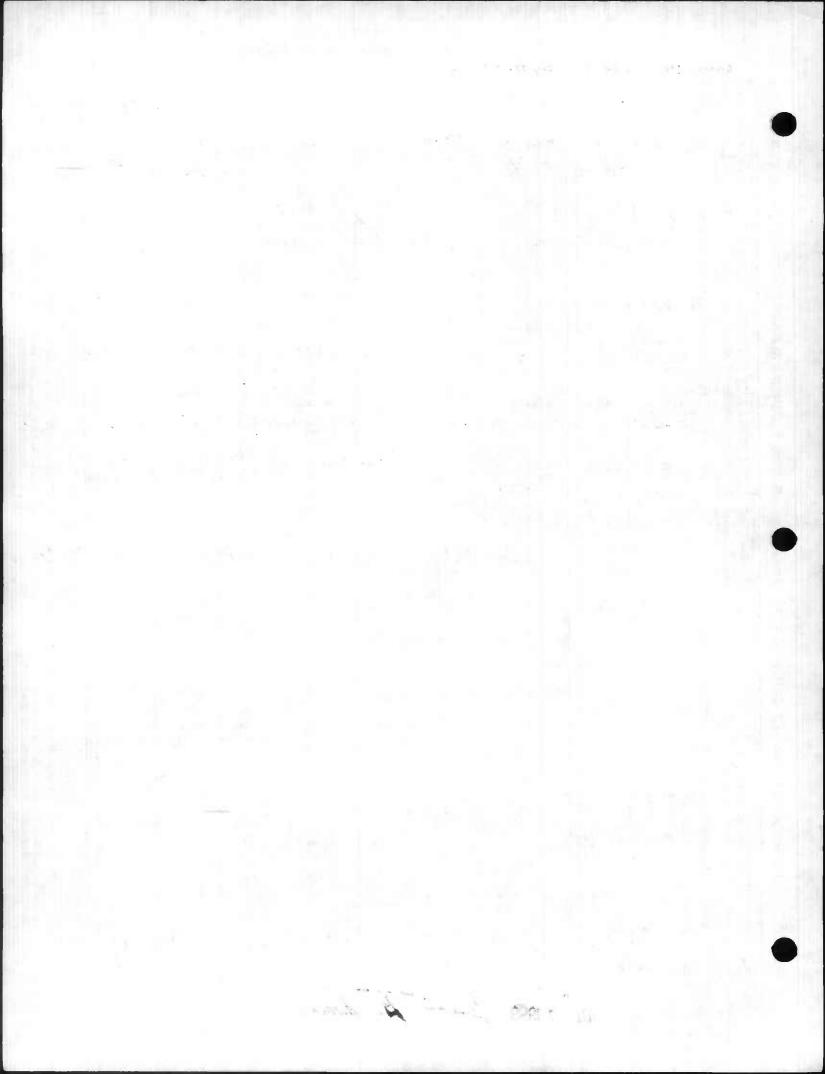
2 0 No

3 Probably 4 Unknown

24b. Were autopsy tindings available prior to completion of cause of death?

1 ☐ Yes

State Registrar



# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

PER FH G773 7/13/99 AH	State of Maryland	Certificate of			Reg. No.	9 2	1241		
1. Decedent's Neme (First, Middle, La	D 0 1	- 1/		2. Date of De	Dey	Year	3. Time of Death		
MINNIE	DRILI	= /		July	9 1	999	2:21 Pm		
48 Fecility Name (If not institution, giv	1	,	4b. City, Town, or I		4c. County	of Death			
Foture Care	2 Home Wood	hirthday) If Under 1 Yes		re		/a			
5. Social Security Number 6. S	To Age (In yrs. last	Yrs. Months Day		8. Dete of Bir (Month, De		Counti			
Usuel Rasidence of Decedent	91			Feb 16	, 1938	Nort	h Carolina		
10a. Stete 10b. County	10c. City, T	own or Location				10	d. Inside City Limits		
MD n/a	Pa	altimore					1 ¥ Yas 2 □ No		
10e. Street and Number		10f. Zip Code			10g. Citizen of V	What Counti	ry?		
4012 Clifton Ave	nije	2.	1216		USA				
11. Maritel Stetus	12. Wes Decedent Ever in U,S. Armed Forces?	13. Wes Decedent of If Yes, specify Cu		pecify Yes or No		e - America			
1 Never Merried 2 Merried	1 Yes 2 No	1 ☐ Yes 21万√N		o rikan, etc.)		ck, White, a	ic.		
3 ☐ Widowed 4 Divorced	Yeer or Detes:	TO THE EXPAN	o Specily.		Specify	Black	k		
15. Decedent's Ed (Specify only highest gra	fucation 1 de completed)	6a. Decedent's Usual Occi	upation e during most of wor	kina	16b. Kind of Bu	usiness/Indu	istry		
Elementary/Secondery (0-12)	College (1-4or 5+)	(Give kind of work don- lifa. DO NOT use retir							
42 C. W. J. M	5+	School Teach	1				ublic Sch		
17. Father's Neme (First, Middle, Last, BRILEY		*.	318: Mother's Nam		, Maiden Suman	na)			
Jasper <del>Riley</del>		· *• · ***	Dora St						
19e. Informant's Name/Relationship (		19b. Mailing Addrass (Stree	140	ral Route Numb	er, City or Town,	Stata, Zip (	Code)		
Kenneth T. Jenki		3711 Brice Ru	un Road		stown, 1		1133		
20a. Method of Disposition 1 DxBurial 2 □ Cremetion 3 □		e of Disposition (Neme of etery, cremetory or other pi	lece)	Date	20c. Location -	City or Tow	vn, Stete		
4 Donetion 5 Other (Special		aine Park Cer			Baltimo				
21. Signature of Funeral Service Licer	see	22. Name end Add	ress of Facility Nut	ter Fun	eral Ho	mes,	Inc.		
of the	Eng W	2501 Gt	wynns Fall	s Pkwy					
23a. Par 1. Enter the diseese, or com shock, or heert feilura. List only	plicetions that caused the death. I			or respiratory e	rrest,		Approximeta Interval Between Onset end Deeth		
Immediate Cause (Final disease or condition resulting in death)	b	s a consequence of):	OMA				YEAR		
Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events									
resulting in death) Last	d	e consequence of):							
Part II. Other significant conditions o	ontributing to death but not resulting	a in the underlying cause of	siven in Pert t	23b. Dtd	tobacco use co	ntribute to	the cause of death?		
END CON CH					Yss 2□No	3 Prob			
END SIHYT	KEIVIJE	DISEASE.							
					an autopsy prined?	con	ra autopsy tindings ilable prior to apletion of cause eath?		
				10	Yes 200No	1□	Yes 2□ No		
25. Was case raferred to medical			26. Place of Dea						
examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatient 2 ☐ ER	/Outpatient 3 DOA	Whon		dence 6 Oth	er (Specify	)		
27. Manner of Deeth  1 Netural 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Year) 28	b. Time of third 28c. this			how injury occur				
3 Suicide 6 Could not be detarmined	28a. Place of thiury - At home building, etc. (Specify)	, ferm, street, fectory, office	0	28f. Location ( City or To	Street and Numb wn, Stete)	per or Rural	Route Number,		
29a. Cartifier (Check only one) 1 Certifying Ph 2 Medical Exam	ysician: To the best of my knowled iner: On the basis of examination and menner stated.	dge, deeth occurred et the and/or investigation, in my	tima, data and place opinion, deeth occu	, and dua to tha rred et the time,	causa(s) end ma date end placa,	annar as sta and due to	ited. the cause(s)		
29b. Signeture and title of certifier	Λ	29c. Licer	nse number		29d. Date signe				
Kanal	Raw no		D18363	2_	7-6	-199	19		
30. Neme and address of person who	completed cause of death (Item 23	la) (Type, Print)	A == :	C					
KOMAC K. DANG	M.D. 3453	WILKENS	Mrt Sur	4 308	· BAC	10'	M024229		
31. Dete filed (Month, Dey, Year)	32. Registrar's Signature	B. Span							
JUL 0 7 199	J. J	W. Ana	1						

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Date of Death Day MARGIE **Physician** ISENNE TT 4b. City, Town, or Location of Death 1999 10:15 am /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Hospice Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 219-26-7952 10 M 20 F 20,1940 Baltimore. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yas 2 No Md N Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 8 5303 L 21239 U5 aven Funeral 12. Was Decedent Evar in U.S. Armed Forces? 1 Yes 2 DNo 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status Black, White, atc. 1 Never Married 2 Married Specify: Black 1 Yes 2 TNo Specify: ð If Yes, Give Year or Dates: ğ 3 Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sr. Teacher Baltimor City Public Schools Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Robert Charles Koselena treeman 19a. Informant's Name/Reletionship (Type, Print) Paughter 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renee Blud Bennett Raven 5303 Balto, 4d 21239 Loe 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State tery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Baltimore, 8 4 ☐ Donation 5 ☐ Other (Specify) Nutter Funeral Homes, INC 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Herbert En Notter 250 Guynns Falls PKWY Balto MD, Z1Z16

23a. Part1. Enter the diseasa, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest,

Approximate shock, or heart feiture. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical METASTATIC ADENOCARCINOMA Examine Examiner Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown C.O. P.D Division of Vital Records. þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed Yargic Bennett 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cesa raferred to medicel axaminer? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Other: 4 Nursing Home 5 Rasidence 6 Nother (Specify) HOS PICE edical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Tima of Injury 27. Mannar of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation Natural 2 Accidant 1 ☐ Yes 2 ☐ No death. within 24 hours after deat To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide Certifying Phyeician: To the best of my knowledge, death occurred at the time, data and place, and due to the ceuse(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) 943 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 34184 30. Name and addrass of parson who completed cause of death (Item 23a) (Type, Print) #100, mD 21204 YORK 7801 TOWSON 32. Registrar's Signatura 31. Data filed (Month, Day, Year) State JUL 0 7 1999 Registrar

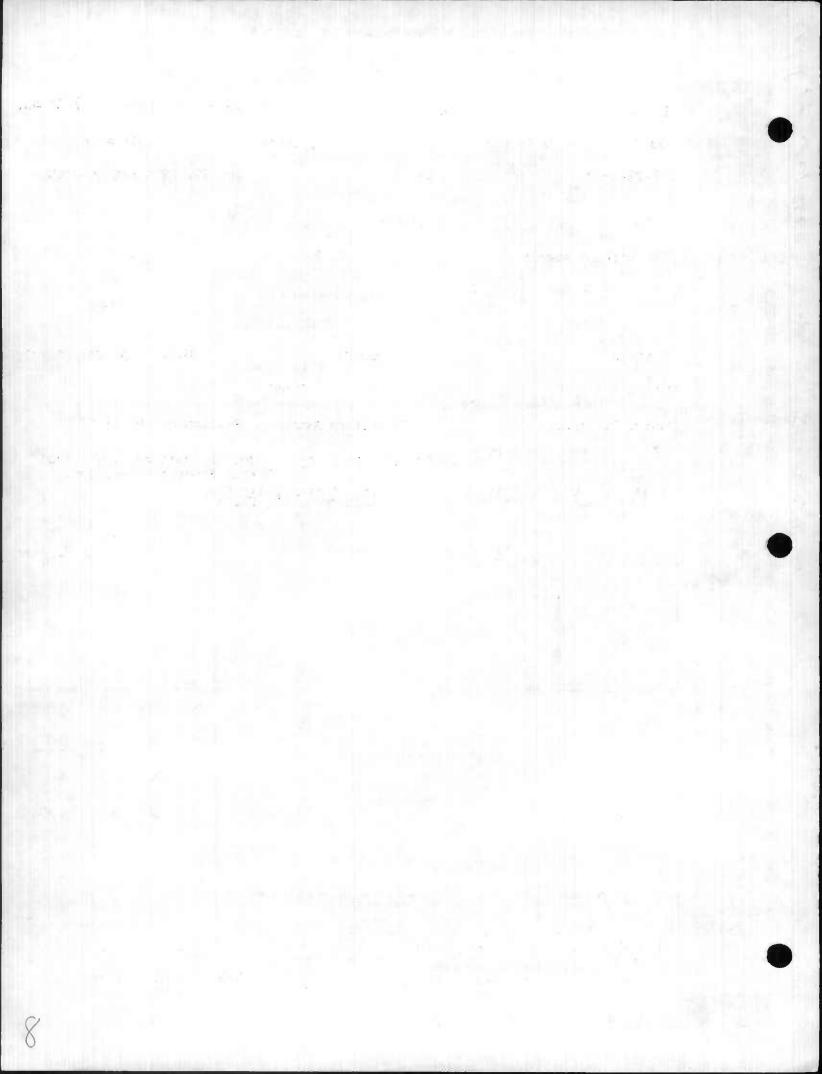
William I was and a glory of the hald september 1. Burning the found than I The state of the s Been H and Will bowers ! the second And the second of the second o The state of the s

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7:30Am 27, 1999 June Beatrice C. Brunson /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner GBMC Gilcrest Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 730Am 1□M 270 F Months Deys Hours Min Yrs. 69 Director 018-22-2699 Feb 27, 1930 Massachusetts Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location t0d. Inside City Limits notified at TV Yes 2 No Director MD n/a Baltimore 0 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Examiner must be 21207 3507 Milford Avenue death Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Black, White, etc. 1 Never Married 2 Married 72 hours after "natural", or 1 ☐ Yes 2 TNo Specify: by 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within 7. el Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Clerk U.S. Corp Army Engineers 12 years Blunson, Bernie 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Lest) h end Mentel h Pages 1 end 2 should be nent of Health end Mentel George Wells Ursel 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) husband Mem 27 la 3507 Milford Avenue Baltimore, MD 21207 George E. Brunson 20e. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20c. Location - City or Town, State Date permit. Pages Department of Important: If it any Injury or c 1 X Buriai 2 □ Cremation 3 □ Removal from Stete July 2 4 ☐ Donetion 5 ☐ Other (Specify) Druid Ridge Cemetery Baltimore, Maryland 22. Name and Address of Fecility Nutter Funeral Homes, Inc. 21. Signature of Funerel Service Licensee 2501 Gwynns Falls Pkwy
Baltimore, MD 21216

23a. Pent1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** 2 /2 year /Medical Immediate Ceuse (Finel CANCEY Luna diseese or condition resulting in death) **Examiner** Due to (or as a consequence of) Examiner The law requires that the deeth certificate be executed and -trans Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): physician a the buriei-Box 68760. Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? signed by the a d be deteched t Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 XYas 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were eutopsy findings evailable prior to completion of cause of deeth? should 24a. Wes en eutopsy Completed ate hes t 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Physiclan: 25. Was case referred to medical exeminer? Be 26. Piace of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 1 Yes 2 No this funeral 28d. Describe how Injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28e. Dete of Injury (Month, Dey Year) Certification: Affer or Attending 5 Pending investigation 1 Neturel n 24 hours after death.

Ne Funeral Director: All pletely filled in by the fu 1 Yes 2 No death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the cause(s) end menner stated. 29e. Certifier edical To the I within 2 To the I complet 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 27, 1999 30. Name and eddress of person who completed causes theath (Item 23e) (Type, Print) N. Charles St. Bolto. md 2120/ Rile. A. GBINC 6701 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State 0 7 1999 Registrar DHMH 16 Rsv 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Butler Bernard 18 30 PM /Medical 4a Facility Name (If not institution, give street, and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital Baltimore W Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** 219-38-6248 10 M 20 F 66 Yrs. September 14,1800 Charles Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or hams 23a or 28a-f ahow edical Examiner must be notified at Baltimore 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2013 U5 21217 Funeral We death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Bleck, White, etc. 11. Marital Status Peges 1 and 2 should be filed within 72 hours after near of Health and Mental Hygiene.

Intil flem 27 is marked other than "natural", or the wirl flem or the traumatte event, in ward at Enrine ury or other traumatte event, in ward at 1 Yes 2 12
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 12 No altimore, Maryland 21215-0020 1 Yes 2 No Specify: Black Specify: Àq 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry htary/Secondery (0-12) College (1-4or 5+) HouseKeeping 6th 17. Father's Name (First, Middle, Last) Be Butles Kobin son 2 19a. Informant's Name/Relationship (Type, Print) Brother 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eddie Baltimore, Md ZIZI7 ave 201. 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State ery, crematory or other place) 1 Burial 2 ☐ Cremation Department important: If any injury or ZIBN Baltimore. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Nutter Funeral Homes 2501 Guynns Falls Pkuy Balto MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Ischemic Cerebral Intarct /Medical Immediate Cause (Final 4 days disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Hypertension Box 68760. years Physician/Medical P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yas 2 No Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient edical Certification: To 2 ER/Outpatient 3 DOA Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation s after death. 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by 4 - Homicide within 24 hours a To the Funeral D Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause of the cause o 29a. Certifier (Check only one) nination and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) To the 29b. Signature will title of certifier 29d. Date signed (Month, Day, Year) 124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - UMGMO Hospital

DHMH 16 Ray 6/95

State

Registrar

Vanessa Rios, MD

JUL 0 7 1999

31. Date filed (Month, Day, Year)

32. Registrar's Signature

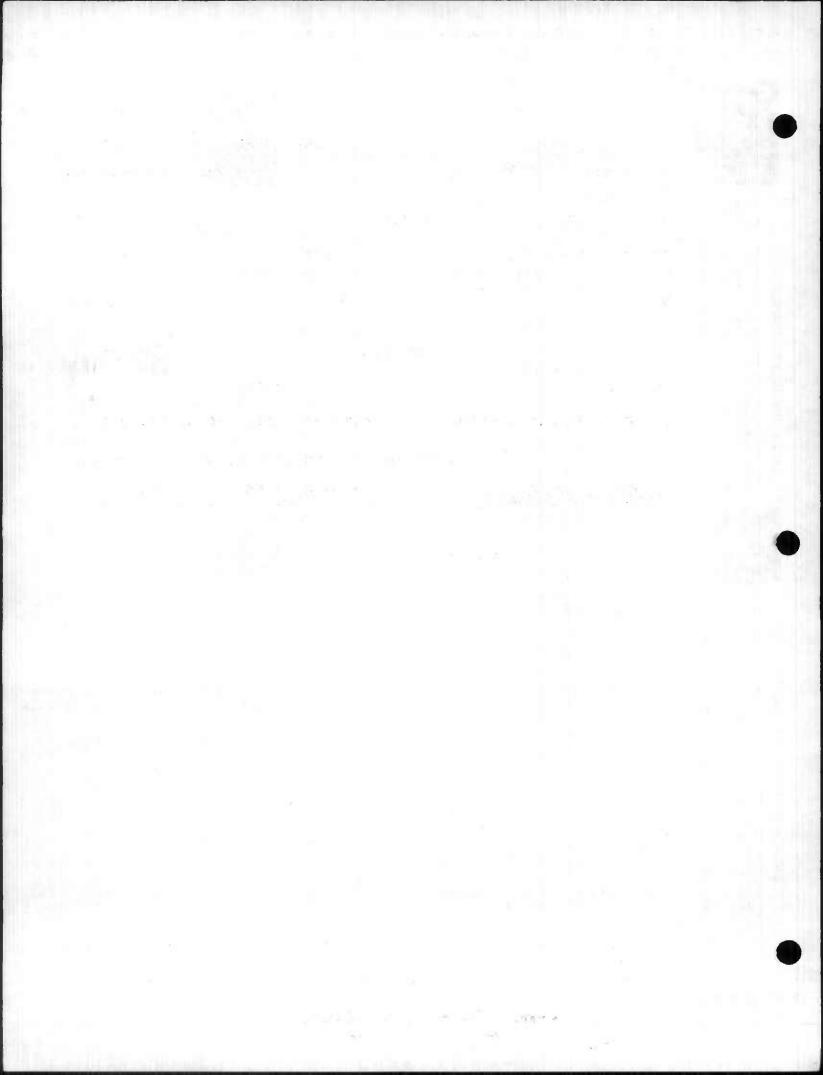
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State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Day Yee **Physician** MARIE BATTON A. 1999 7:50 AM JULY /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town. or Location of Death 4c. County of Death Examiner CHURCH HOME BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. Months | Deys | Hours | Min. 8. Dete of Birth (Month, Dey, Year) 9. Birthplece (Stere Country) 01/26/1900 MARYLAND 5. Social Sacurity Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 1□ M 2 F Deys Vre 214-74-3177 99 Director Usuel Residence of Decedent the Meryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23s or 28s-1 show 1 Yes 2 □ No Director N/A MD BALTIMORE 10e. Street end Number 10f. Zip Coda 10g. Citizen of What Country? Peges 1 and 2 should be filed within 72 hours efter death with ment of Health and Mental Hygiena.

Int. If Itam 27 is marked other than "natural", or items 23a or italy or other than the Mental Hygiena. 101 NORTH BOND ST. 21231 USA Funeral 12. Was Dacedent Ever in U,S. Armed Forcas? 14. Race - American indien, Bleck, Whita, atc. Was Decedant of Hispanic Origin? (Specity Yas or No-If Yes, specify Cuben, Maxican, Puarto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Detes: 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: 3 Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) HOUSEWIFE HOMEMAKER 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be UNKNOWN UNKNOWN 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) PAT CROYLE (ADMINISTRATOR) 101 NORTH BOND ST. BALTO., MD. 21231. 20b. Place of Disposition (Neme of cemetery, cremetory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremetion 3 ☐ Removel from State permit. Pege Department of Important: If any injury or 4 □ Donetion 5 □ Othar (Specify) GREEN MOUNT CREMATORY 07/07/99 BALTO, MD. 21. Signature of Funerel Sarvice Licensae 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21 23a. Pert1. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardlec or respiretory errest, shock, or heart feilure. List only ona cause on each line. Approximate Interval Between Onsat and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ASCVD Examiner Due to (or es e consequence of): Examiner ician end burial-transit The law requires that the death certificeta be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting In death) Lest Due to (or es e consequença of): physician the buria Box 68760. Physician/Medical Due to (or es e consequença of) 80 esn esn P.0. Pert II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings aveileble prior to completion of cause of death? 24e. Wes an eutopsy performed? plyone Completed page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director. Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 After this funerai 27. Manger of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. injury at Work? 28d. Describe how Injury occurred Certification: 1 Naturel 5 Pending 1 Yes 2 No investigation 24 hours after death. 2 Accident the 8 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stele) 28e. Pleca of Injury - At home, ferm, street, fectory, office bullding, etc. (Specify) filled in by 4 | Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner as steted. Medical within 24 ho To the Fune completely fi (Check only one) 2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licanse number 29d. Date signed (Month, Dey, Year) 29b. Signature end titla of certified D16619 30. Name end eddless of person who completed cause of death (Item 23e) (Type, Print) E. VERGARA-SOARES BALTIMORE 101 N BOND 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State

Registrar



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Elizabeth Mary July 1999 4:10 PM 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mariner Health of Forest Hill Forest Hill If Under 24 Hrs. 8. Date of Birth Hours Min. Sept. 21, 1902 If Under 1 Yeer 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2XX Months Deys Maryland 214-22-5093 96 Usual Residence of Decedent 10b. County 10a. State Mary Land 10c. City. Town or Location 10d. Inside City Limits Harford Belair, Maryland 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 144 North Hickory Avenue 21014 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 2 2 No If Yes, Give Year or Dates: 14. Rece - American Indian, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Merried 1 Yes Z No Specify: Specify: White 302 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4th grade Assembly Line Worker Sinjin 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) Frederick John Belschner Annie K. Lang 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mr. Russell C. Baker, Jr. 7 Love Bird Court Baltimore, Md. 21236-2977 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State Woodlawn Cemetery 7-8-99 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funeral Service License 22 Name and Address of Facility Home 7401 Belair Rd. Baltimore, Md. or heart failure. List only one cause on each line teations that caused the death. Do not entar tha moda of dying, such as cardiac or raspiratory arrest, Approximata Intervel Between Onset and Deeth Immediate Cause (Final diseese or condition resulting in death) Due to for as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical examiner? 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury st Work? 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicida

Examiner hysician and the burial-transit Box 68760. physician Physician/Medical 88 Division of Vital Records, P.O. signed by the p Completed peen Be To edical Certification:

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

r than "natural", or hams 23s or 28s-f show the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be liked Department of Health and Mental Hygin Important: If Item 27 is marked other any injury or other traumatic event.

**Physician** /Medical

Examiner

Director

Funeral

30

Completed

Be

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Arter death.

\*I Director: After the 'in by the fur

State

Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier (Check only

615

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

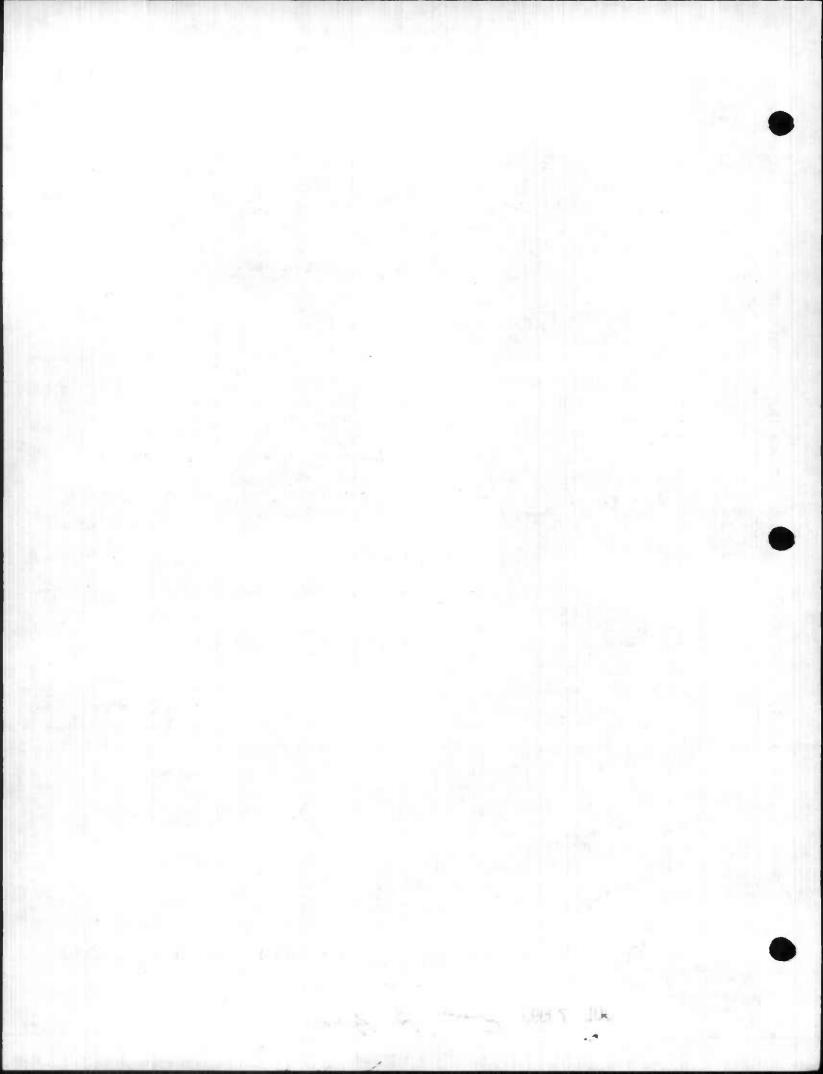
32. Registrer's Signeture

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D3225

29d. Date signed (Month, Day, Year)



# Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dev Year JERRY BOYD JULY 1999 5:49PM 4c. County of Deeth 4e Facility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Death ST. AGNES HEALTHCARE BALTO . If Under 24 Hrs. 8. C N/A 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 8. Dete of Birth (Month, Day, Year) Birthplace (Steta or Foreign Country) Days Months 10XM 2□ F Hours 96 324-12-9433 06-22-03 PENSACOLA, FL Usual Residence of Decedent 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits MD N/A BALTIMORE 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3330 WILKENS AVENUE 21229 U.S.A. 14. Race - Amarican Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detas: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☑ Merried 1 Yes 2 No BLACK Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grads completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 RAILROAD PORTER 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) UNKNOWN UNKNOWN 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 1519 ADDISON RD, SOUTH FORESTVILLE, MD ce of Disposition (Name of Dete 20c. Location - City or Town, State ETHEL PRICE 20747 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Mathod of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 7-7-99 METRO CREMATORY 4 ☐ Donation 5 ☐ Othar (Specify) baltimore, md 22, Nema end Address of Fecility nument Funerel Service Liceria HOWELL FUNERAL 4600 LIBERTY H AL HOME HGHTS AVE, BALTO. MD 21207 Part Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, auch as cerdiac or respiretory arrest, shock, or heart feilure. List only one cause in each line. Approximate interval Between Onset and Death Immediete Cause (Finel diseese or condition resulting in deeth) a colon cancer unknown Due to (or as e consequence of): gi-rectal bleeding unknown Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as e consequence of): Due to (or es e consequence of):

The law requires that the death certificate be executed physician s the burial of Vital Records, P.O. Box 68760. or Attending Physician:

this thin 24 hours after death. the Funeral Director: Aft mpletely filled in by the fur

by Physician/Medical

Completed

Be

Medical Certification: To

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be

**Funeral** 

Director

show

28a-f

must be

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Pages 1 and 2 should be the ment of Health and Mental H lant; if them 27 is marked oth lary or other traumatic event

**Physician** /Medical

Examine

filed within 72 hours after

Baltimore, Maryland 21215-0020

Part II. Other significant conditions of PROSTATE CA, MU	entributing to death but not res	sulting in the underlying o	causa given in Pert I.	23b. Did lobacco uae co	ontributs to the cause of death?  3 Probably Unknown				
EMENTIA, DIABE	TES MELLITU	S		24a. Wes an autopsy performed?	24b. Were autopsy findings eveileble prior to completion of cause of deeth?				
ITN, HYDRONEPHR	OSIS			1□ Yes 2 No	1 ☐ Yes 2 ☐ No				
25. Was casa referred to medical			26. Place of De	seth (Check only one)					
axaminer? 1 ☐ Yes 2 No	Hospitel: 1 Nopatient 2	ER/Outpatient 3 De	OA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐Ot	ne 5 Residence 6 Other (Specify)				
27. Manner of Death  1. Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury et Work? 1 \( \text{Yes} \) 2 \( \text{No} \)	28d. Describe how injury occu	rred				
3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Specia	ome, farm, street, factor (y)	y, office	28f. Location (Street and Num City or Town, State)	ber or Rurel Route Number,				
				ce, and due to the cause(s) and mourred et the time, date end plece					
29b. Signaturit and titla of contillur	ow MO	29	License number	t Jul	ed (Month, Dey, Year)				

State Registrar 31. Deta filed (Month, Dey, Year) 7 1999

900 32. Registrar's Signatura

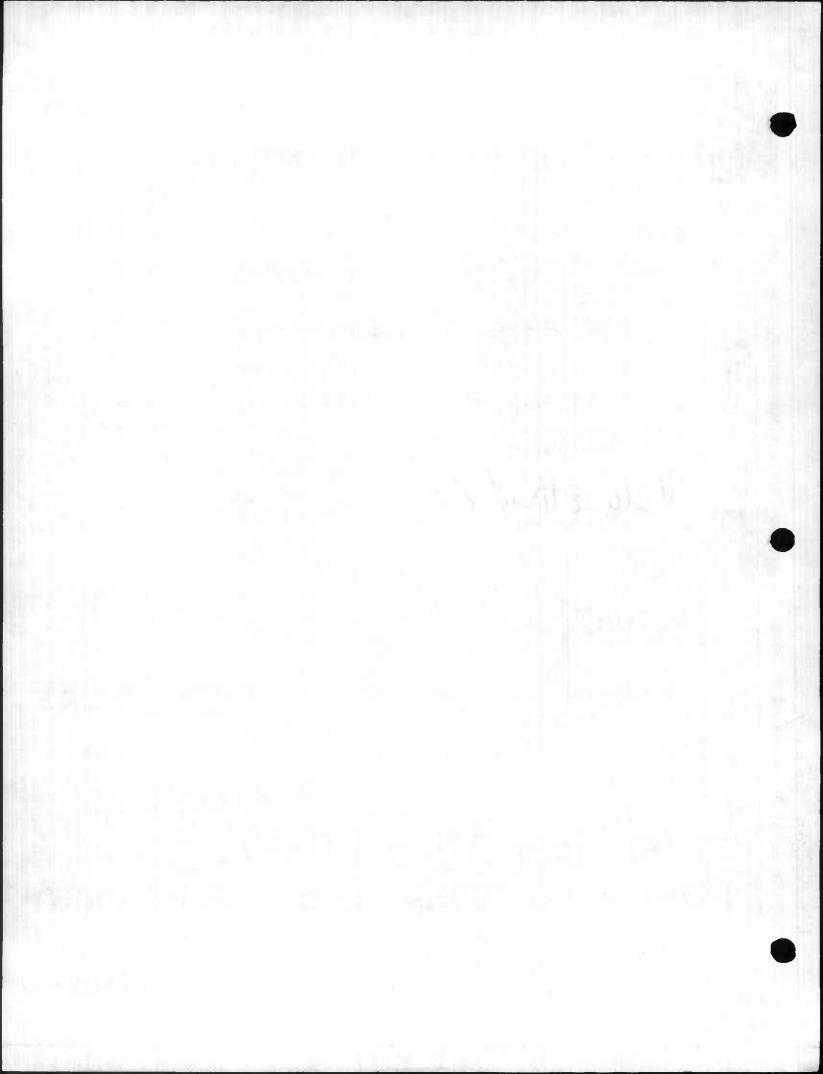
30. Name end address of person who completed ceuse of deeth (Item 23a) (Type, Print)

CATON AVE, BALTIMORE, MO 21229

**DHMH 16 Rev 6/95** 

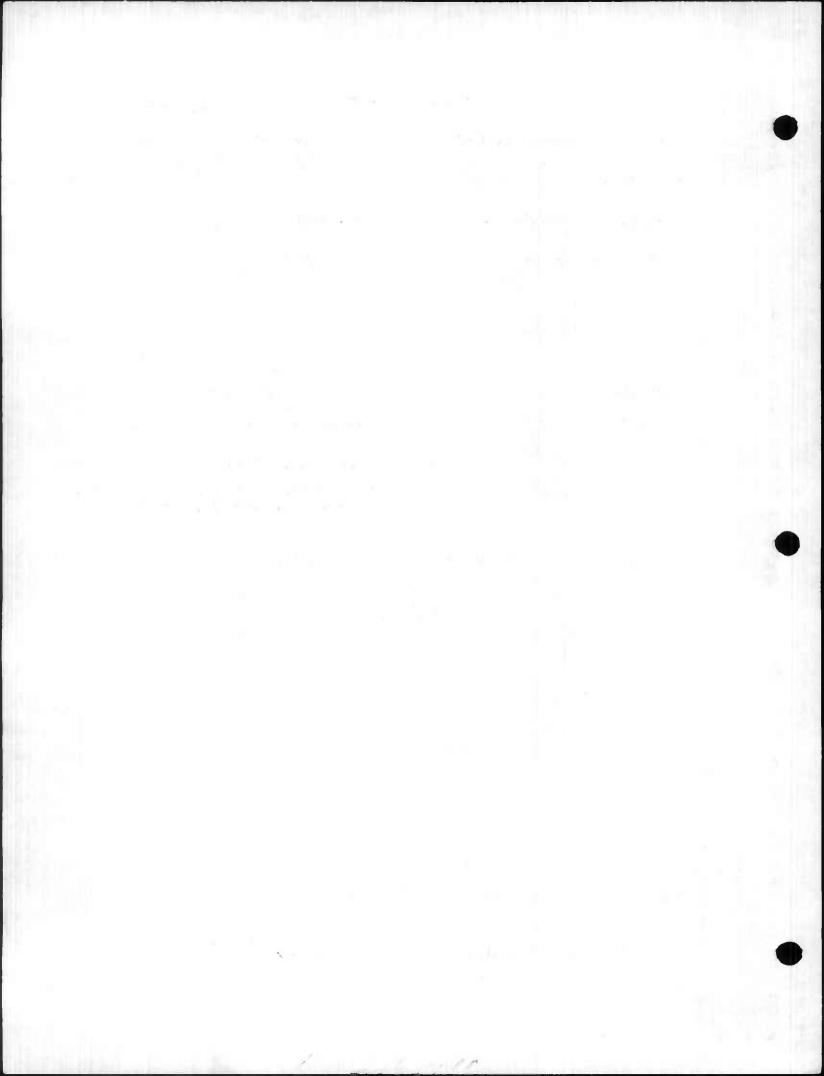
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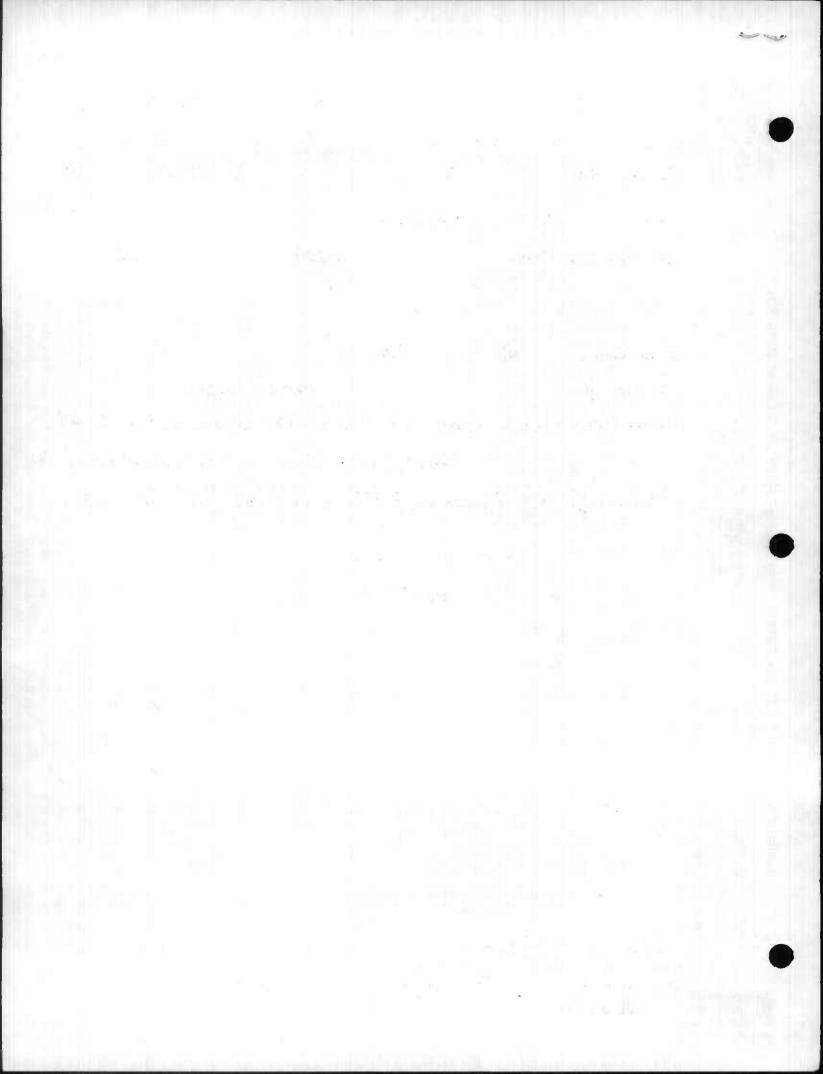


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State Registrar **DHMH 16 Rev 6/95** 



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Yee **Physician** VANESSA 30 CLARK-EL JUNE 1999 06:45PM /Medical 4c. County of Death 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Undar 1 Yaar | If Under 24 Hrs. 7. Aga (In yrs. last birthday) (State or Foreign **Funeral** Days 215-60-4 1 M 2 F Vrs **Director** Usual Residence of Decedent deeth with the Maryland 100 City, Town or Location 10d. inside City Limits show r than "naturel", or items 23a or 28a-f sho the Medical Examiner must be notified at 1 des 2 No Director 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 1202 6 Funeral Was Dacedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puarto Ricen, etc.) Was Decedent Ever in U,S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, atc. Pages 1 and 2 should be filed within 72 hours efter nent of Heelth end Mental Hygiene.
int: If item 27 is marked other than "naturel", or ite 1 Never Marriad 2 Married Yes 2 Yes, Give 2 1 No Baltimore, Maryland 21215-0020 1 Yes 2 No Specify. Specify: þ 3 Widowed 4 Divorced Yaer or Detes: Completed 16e. Decedant's Usuel Occupetion
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 100 7 is marked other traumatic event, I -Father's Name (First, Middle, Last Be 0 20b. Plece of Disposition (Neme of 20e. Method of Disposition permit. Pages Dependent of Important: If it any Injury or or 1 ☑ Buriel 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximata Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final diseese or condition resulting in death) PNEUMONIA 04 DAYS Examiner Due to (or as a consequance of) Examiner SEIZURE 04 DAYS physician end the burief-transit requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Lest Due to (or as a consequence of): Records, P.O. Box 68760 MONTHS c. PROGRESSIVE MULTIFOCAL LEUKENCEPHALOPATHY Physician/Medical Due to (or es a consequence of) 98 AIDS YEARS signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown RENAL FAILURE þ 24b. Ware eutopsy findings aveileble prior to 24e. Was an autopsy Completed completion of cause of death? irector, page 2 s 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Wes case refarred to medical examiner? Be 26. Piece of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 3□ DOA 1 ☐ Yes 2 X No 1 ☑ Inpatient 2 ☐ ER/Outpatient this 28e. Date of Injury (Month, Dey Year) funeral 28d. Describe how Injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury et Work? Certification: After 5 Pending Investigation 1 X Neturel efter death. 1 ☐ Yes 2 ☐ No 2 Accident n 24 hours efter dea ne Funeral Director pletely filled in by th 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 ☐ Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide Hospital Medical 29a. Certifier 1 🖄 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) end menner as stated. To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. (Check only one) 29b. Signeture and title of certifier 29c. Licensa number 29d. Data signad (Month, Day, Year)

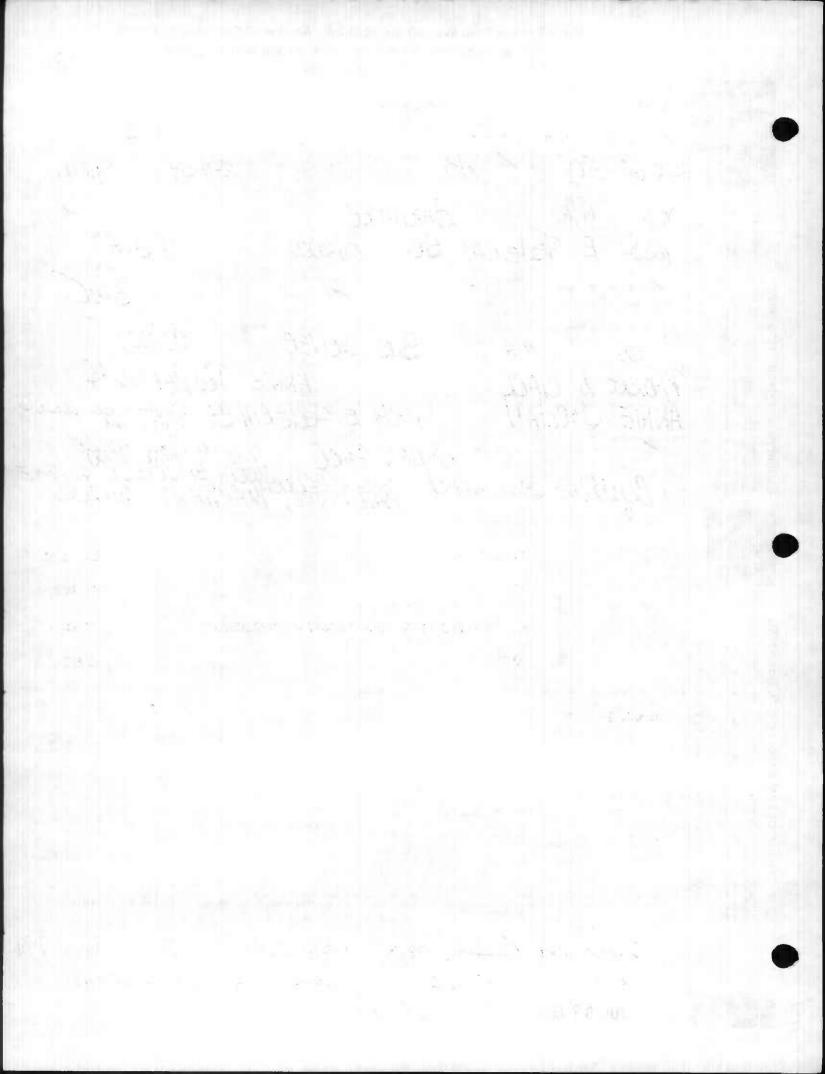
State Registrar 31. Date filed (Month, Dey, Year) **JUL 0 7** 1999

32. Aegistrar's Signature

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)

JOHNS HOPKINS

RES-000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 3. Time of Death 1. Decedent's Nema (First, Middle, Last) Dev JUNE 1999 Pauline Josephine Critzer 30 4a Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE CITY Baltimore Union Memorial Hospital Hours Min. 8. Dete of Birth (Month, Dey, Year)
Aug. 13, 1920 If Under 1 Year Months Deys 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country)
 Ohlo 1 M 204 78 214-24-8097 Ususi Residenca of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a Stete 10h County ¥¥Yas 2□ No BALTIMORE CITY Maryland Baltimore 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code United States Apt. 1601 21201 124 W. Franklin St. 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 2 No If Yes, Give Yeer or Datas: 14. Race - Amarican Indian, Black, Whita, etc. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White 1 Yes 20 No Specify: 3 ☐Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Nama (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Maud Terry Pete Strickley 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3219 Lily Ave. Apt. D Baltimore, MD 21227 Esther Bathgate/Daughter 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) July 3Dete 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete Crestlawn Mem. Cem. 1999 Marriotsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Faggral Service Licensee 22. Name and Address of Feeility
Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061 23a. Pert1. Errer the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Final Status epileptians disaasa or condition resulting in deeth) strok Drobable Sequentielly list conditions, if eny, leeding to immediate cause. Enter Undarlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of) Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 40 Unknown Diabetes milliting, Renne failure, hyperterson, 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was en eutopsy Coronay antry disease 1 Yes 2 No 1 Yes 2 No 26. Piece of Deeth (Check only ona) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Tima of 28d. Describe how injury occurred 5 Pending investigation 1 Yas 2 No 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Examiner The law requires that the death certificate be executed physicien end the buriel-tran Division of Vital Records, P.O. Box 68760 signed by the e been si is certificate har To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I

**Physician** 

/Medical

Examiner

**Funeral** 

Director

"natural", or items 23s or 28s-f ehow edical Examiner must be notified at

the Medical

filed within 72 hours effer death with the Hygiene.

Pages 1 and 2 should be file ment of theelth end Mentel Hy ant. If them 27 is marked oth jury or other treumstic even

Department of Important: If any injury or

**Physician** 

/Medical

**Examiner** 

altimore, Maryland 21215-0020

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the Marylend

1 Yas ZNNo 27. Menner of Deeth 1 Neturel 2 Accident 3 Suicida 4 Homicide

29e. Certifier

Physician/Medicai by Completed Be 10 Certification: edicai

25. Wes case referred to medical

\*\*Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and title of certifier Somaan, M.D.

29c. License number AT2438946C12

29d. Dete signed (Month, Day, Year) JUNE 30, 1999

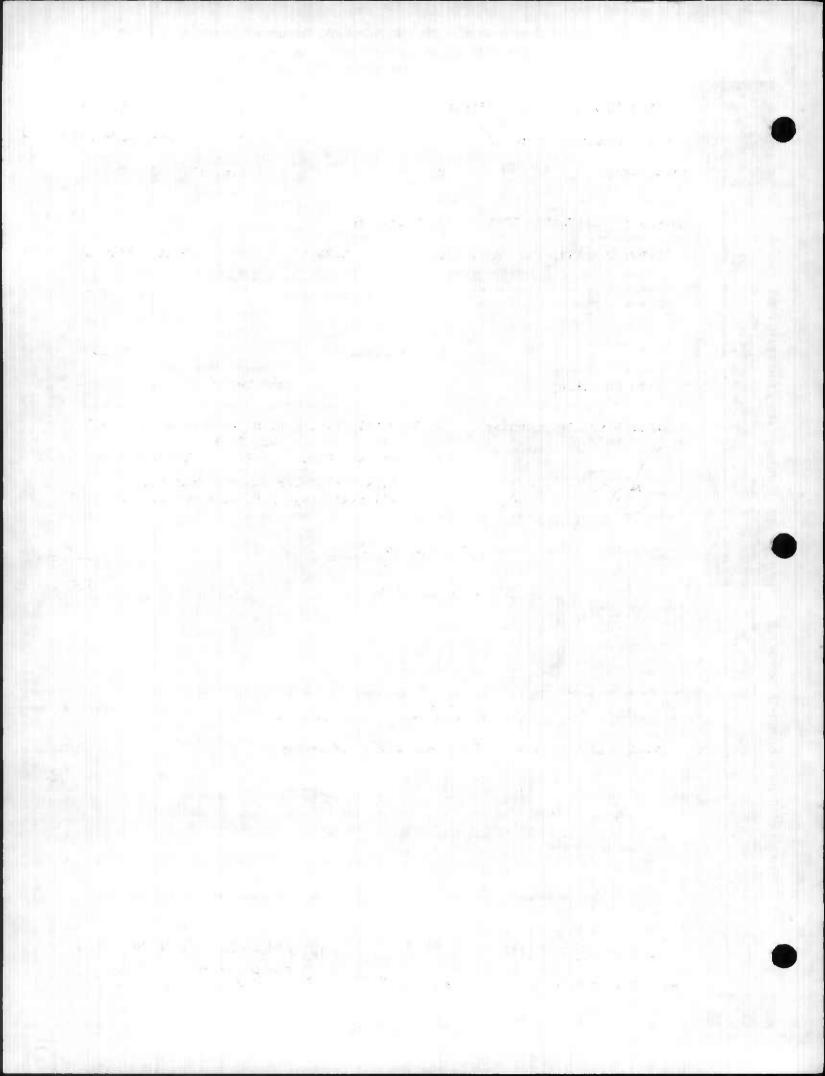
30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

cause of deeth (Hem 23e) (Type, Print)
Union Memorial Hospital BAChmore MO 21218 HUSAM SEMAAN M.O.

31. Date filed (Month, Dey, Year) 071999

32. Registrer's Signeture B. Sports

State Registrar



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decadent's Nama (First, Middle, Last) 2. Data of Death Day Joseph 9:07am FOUL 2014 4c. County of Deeth Baltmore City 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of topkine Bayview Medical Center Baltimore Hours Min. 8. Data of Birth (Month, Day, July 23) 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year Birthplaca (State or Foreign Country) Days Maryland 216-01-6492 79 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3510 Brendan Avenue 21213 U. S. A. 12. Was Decedent Ever in U,S. Armed Forces? 1 (X) Yas 2 No If Yes, Giva Year or Datas: WW] [] Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th Grade Tool & Die Maker Martins 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Stephen Czyz Josephine Gazdowicz 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3510 Brendan Avenue, Baltimore, Maryland 21213 Louise R. Czyz 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 7/7/99 Holy Rosary Cemetery Baltimore. Maryland 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licenses Polent 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death Immediata Causa (Finat diseasa or condition resulting in death) 5 Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. Stata

**Funeral** 

Director

rai', or items 23a or 28a-f ahow Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after deeth 1 Department of Health and Meniel Hydene. Important: If Itam 27 is marked other than "natural", or Itams 23s any Injury or other treumatic event, the Medical Examples must page.

Baltimore, Maryland 21215-0020

68760.

of Vital Records, P.O. Box

Division

Director

Funeral

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Completed

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The law requires that the death certificate be executed physician s the burie 8 signed by the at d be detached for page 2 s

Examiner Physician/Medical þ Completed certificata director, 8 Certification: To this funeral After

or Attending Physician: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun

Registrar

Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to 24a. Wes an autopsy performed? completion of causa of death? 20 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitat: 1 punpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yas 2 No Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Netural 5 Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be detarmined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier MD

20314

29d. Dala signed (Month, Day, Year)

Bayvicu Medical Center, 4940 Eastern Avenue, Baltimore MD ZRZY

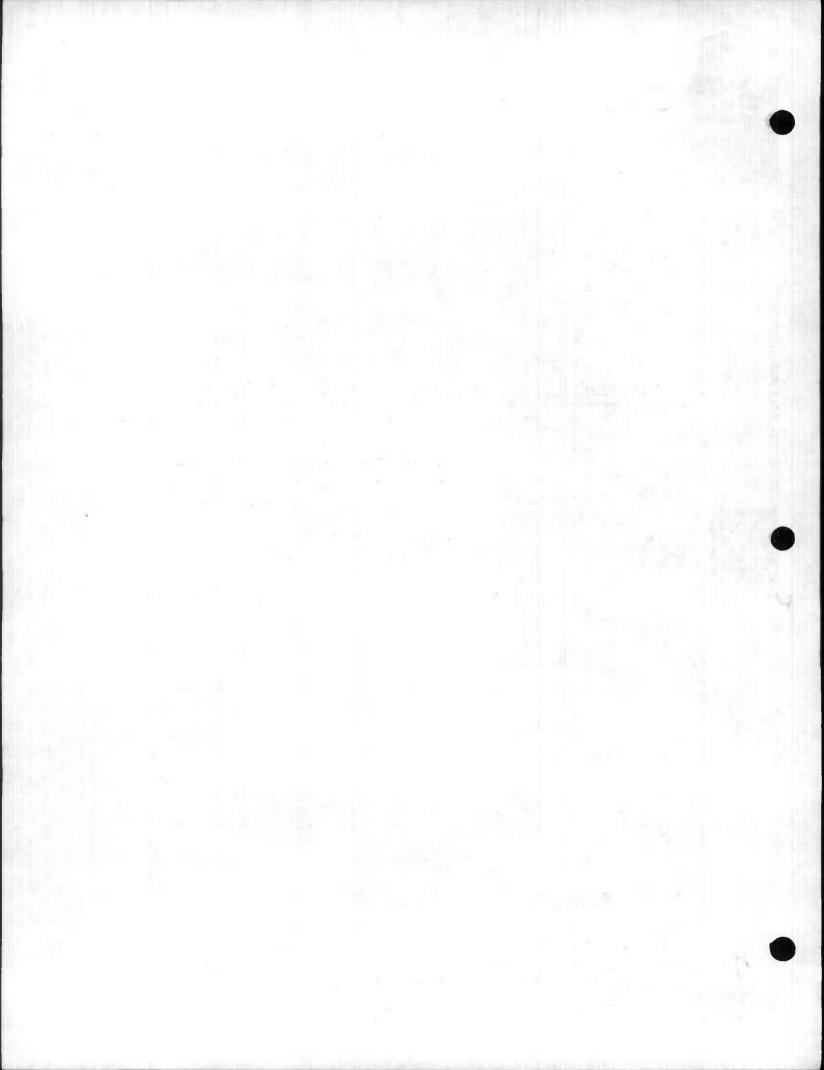
31. Date filed (Month, Day Year)

Sensor Signatura

32. Registrar's Signatura

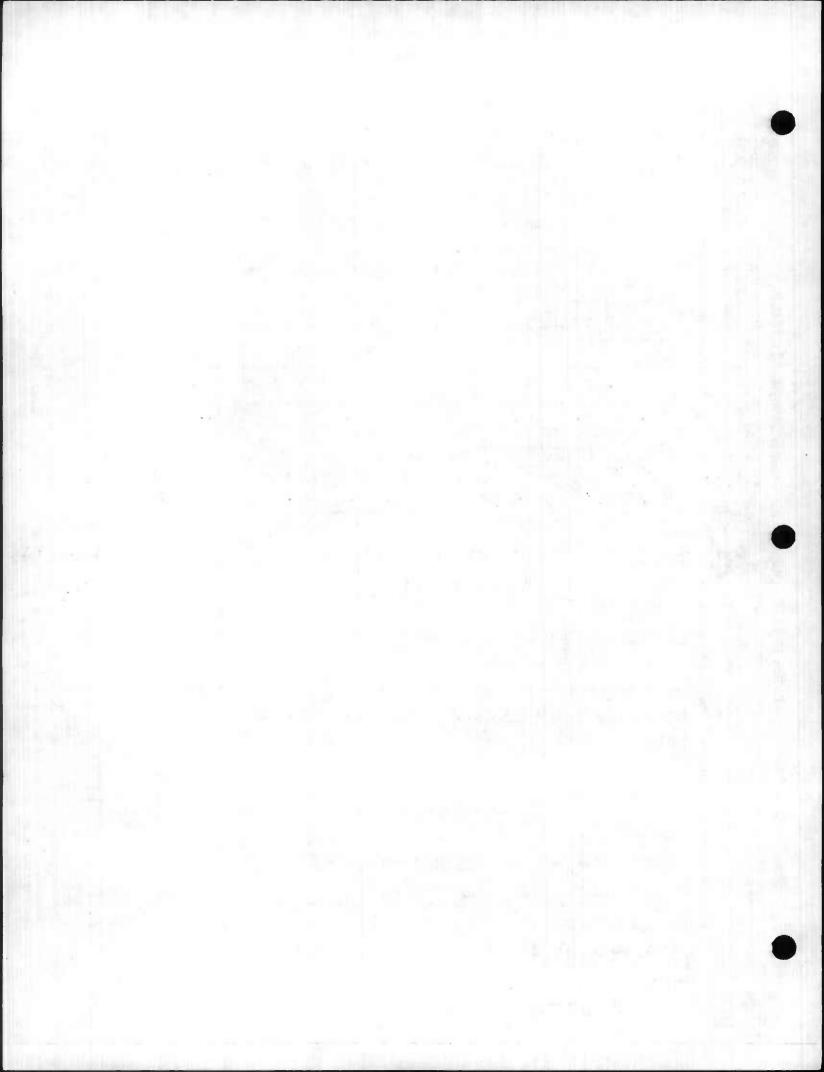
L. 30. Nama and addrass of person who completed cause of death (Item 23e) (Type, Print) Crohow W- Redgrave, M.J., Jours Hopkins

(Check only one)



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Deeth Month **Physician** 10:30 g.m. William Clark /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Baltimore Rosedale If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Months Hours 1X M 2 ☐ F Yrs. Director 215-01-5914 15,1912 Maryland 86 Dec. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Itams 23a or 28a-f ahow 1 ☐ Yes 2 ₺No Director Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21219 United States 2825 Lodge Farm Road Apt. 429 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? Race - American Indien, Bleck, White, etc. 11. Marital Status o filed within 72 hours after di al Hyglens. other than "natural", or flem vent, the Hedden Emman. 1-Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Merried 21215-0020 1 Yes 2√2 No Specify: Specify: White by WWII 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Sheet Metal Construction altimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) .. Pages 1 and 2 should be fit the ment of Health and Mental H hant: If ham 27 is marked off jury or other traumatic aver Be Elizabeth L. Birx Harry C. Clark 0 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Rita M. Clark / Wife 2825 Lodge Farm Road Apt. 429 Edgemere, MD 21219 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, Stete cemetery, crematory or other piece) 1 DBurial 2 Cremetion 3 Removel from Stete permit. Page Department of Important: If any injury or ansea. Oak Lawn Cemetery July 8,1999 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) peral Survice Licens 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) Examiner Bronchieck Examiner physicien and s the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Cardiovasavar Records. should be o 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: 8 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: 1□ Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending investigation after death. 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. To the To the To the F 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) A. W.D 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) MI 1560 P 32. Registrar's Signature State 0 1999 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. B.K.S State of Maryland / Department of Health and Mental Hygiene Q MICHAEL DELORENZO Certificate of Death AMEND ITEM#23a,27&28a-f PER MEO. G773 7-22-99 J.A. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** MICHAEL 5, 1999 2157 PM DELORENZO JULY /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE **ESSEX** FRANKLIN SQUARE HOSPITAL If Under 24 Hrs. If Under 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 30 M 20 F Months 218-11-8410 Director MD Usual Residence of Deceden 10e. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1. Yes 2. No Directo ESSEX 280-1 BALTIMORE MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 21221 \*natural", or hams 23a GLENWOOD RD. USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U.S. Armed Forces?

1 Yes 2 D No If Yes, Give Year or Datas: 14. Race - Amarican Indian. 11. Meritel Status Black, Whita, atc. 72 hours after 1. Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1□ Yes 2□No Specify: Specify: à 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. other than flied within Elementary/Secondary (0-12) College (1,-4or 5+) VEVER WORKED 12 n permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important, if them 27 is marked other any injury or other traumatic event. It 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Father's Nama (First, Middle, Last) Be ATHERINE DELORENZO UNKHOWN 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Head 37 GEN 42

20b. Place of Disposition (Name of cemetery, crematory or other place) G EN WOOD ATHERINE DELORENZO (MOTHER) RD ESSEX Md. 21221 Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition 7/9/ 12 Burial 2 ☐ Cremetion 3 ☐ Removal from State Holy REDEEMER CEM. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Deprises 22. Nama and Address of Facility

DELLANOCE + SONS F.K. HiGA ST. BALTO. 322 5. 2/202 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failura. List only one cause on each line. Approximete Intarval Batween Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition rasulting in death) ADRENAL INSUFFICIENCY COMPLICATED BY HEAT EXPOSURE Examiner Due to (or as a consequence of) Examin the burial-transit that the deeth certificate be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury pug Due to (or as a consequence of): Box 68760 attending physician Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) 82 USB P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 288 1 TY Yes 1 2 Yas 2 No 2 1 No Division of Vital 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Yas 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28d. Describe how injury occurred 27. Manner of Death 28a. Data of Injury 28b. Tima of 28c. Injury at Work? Certification: After To the Mospital or Attending Within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending invastigation after death.

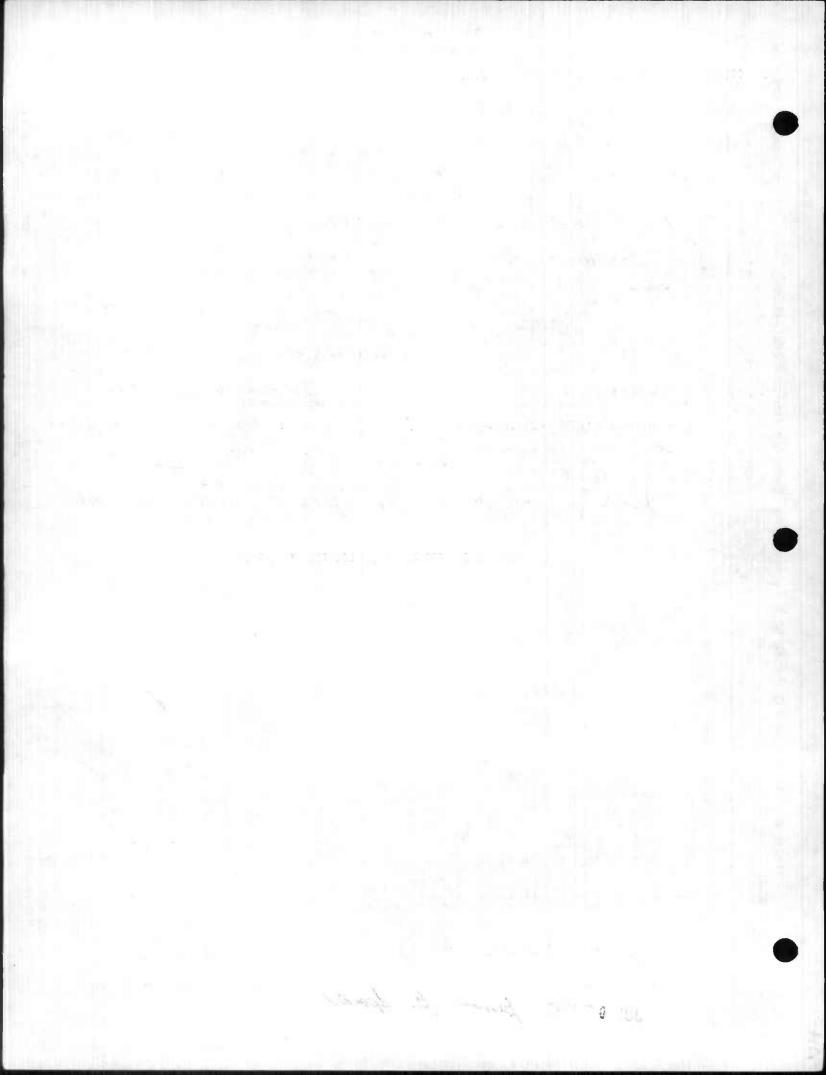
Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 7/5/99 EXPOSURE TO HEAT 9:04 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)
HOME 4 T Homicide 371 GLENWOOD RD., ESSEX, MD. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) JULY 6, 1999 O.C.M.E 30. Name and ar ress of person who completed cause of death (Item 23a) (Type, Print) estancoll Penn Street, Baltimore, Maryland 21201 DSC JUL 0 7 1999 37. Registrar's Signature

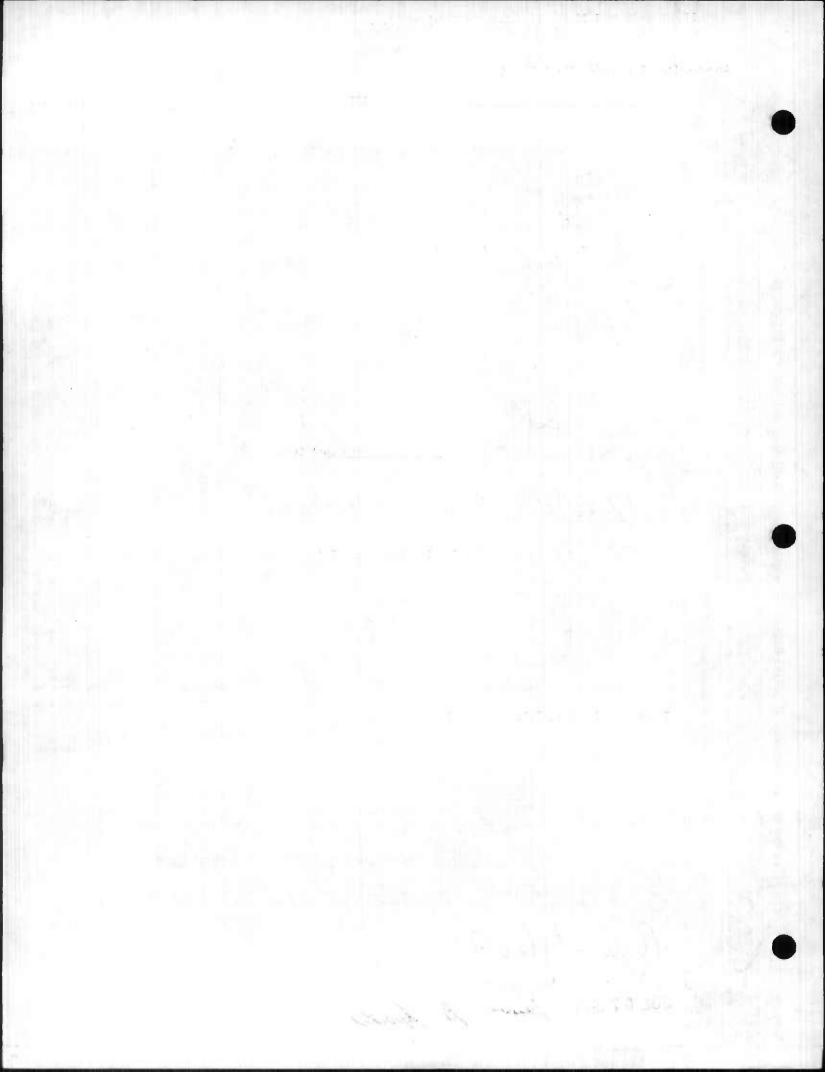
State Registrar

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**DHMH 16 Ray 6/95** 



DONING DESITEM	or Print in Black of Maryland / D	c Indelible	of Health and	Mental Hy	giene 9	ble. 9 21255
1. Decadent's Name (First, Middle, Last)	ŁW ,	Certificate	Ol Deall!	2. Dete of De	Reg. No.	3. Tima of Death
Physician /Medical	WIII	ANA DEWITT	- Ch. T	Month JULY	3, 199	
Examiner 4s Facility Name (If not institution, give street and			4b. City, Town, or		4c. County	of Death
UNIVERSITY SHOCK TR  5. Social Security Number  6. Sex  1 M 2/4  Usuat Residence of Decedent	7. Age (In yrs. last birt	hday) If Under 1 Months	Year If Under 24 Hrs. Deys Hours Min.	8. Date of Bir Month, Da	y, Year).72	9. Birthplace (State or Foreign Country)  WAShington D.C
10a. State 10b. County  10a. State 10b. County  10a. State 10b. County  10b. Street and Number  10c. Street and Number  11. Marital Status  11. Merrial Status  12. Was D  Armed  13. Was D  Armed  15. Decedent's Education  (Specify only highest grade complete  (Specify only highest grade complete  Elementary/Secondary (0-12)  College	10c. City, Town	orLocation	2			10d. Inside City Limits 1. Yes 2 □ No
10e. Street and Number	alto 1.	10f. Zip C	10 15		10g. Citizen of V	Whet Country?
11. Marital Status  12. Was D  Armed  1 Never Married 2 Merried  1 Never Married	pecedent Ever in U,S. Forces?	13. Was Decede	nt of Hispanic Origin? (S y Cuban, Mexican, Puert	pecify Yes or No	- 14. Rac	e - American Indien,
1 Never Married 2 Merried 1 Never Merried 2 Merried 3 Merried 2 Merried 2 Merried 2 Merried 2 Merried 2 Merried 2 Merried 3 Merried 2 Merried 2 Merried 3 Merried 2 Merried 3 Merried 2 Me	s 2 No		No Specify:	o rican, etc.)	Specify	ck, White, etc.
3 Widowed 4 Divorced If Yes, Year of Specify only highest grade complete (Specify only highest grade complete Elementary/Secondary (0-12)	e (1-4or 5+)	Decedent's Usual (Give kind of work life. DO NOT use	Occupation done during most of wor retired)	rking	16b. Kind of B	usiness/Industry
N pas	)	DISAB	18. Mother's Ner	me (First, Middle,	Maiden Şuman	10)
De production of the productio	mother 196.	Mailing Address (	France Street and Number or Ry	LS MC	TE LOL er, pity or Town,	very Dewitt State. Zip Code)
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O 65 2 1 Rurial 2 Cremetion 3 Democratifer	and a second second	Disposition (Name v, cremetory or oth		7/d/aa	20c. Location	City or Town, Stata
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m and an	111	Josep	h L. Teys	Stune	Val TTO	me 7/21/
234 Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. Do n	ol enter the mode	of dying, such es cardiac	c or respiretory e	rest,	Approximete Intervel Between
Physician						Onsel and Death
Immediate Cause (Finel disease or condition resulting in death) a	HYPERTENSIVE		PATHY			1
<u> </u>	Due to (or es e c	onsequence of):				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a c	onsequence of):				
if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):				
BOX 68						
Do anticological desired of the second of th	d - 10 - 10 - 10 - 10 - 10 - 10 - 10 - 1		and the Second	on Did		ntribute to the cause of death?
The second to mediate cause. Enter Undertying Cause. (Disease or injury that initiated events resulting in death) Last  Compared to the second	200C 1711/177 111		use given in Pert I.			3 Probably 4 Unknow
					en eutopsy med?	24b. Wera autopsy findings available prior to completion of cause of death?
The lew atta has pege 2				10	Yes No	1 ☐ Yes 2 ☐ No
25. Wes case referred to medical examiner?				ath (Check only o	one)	
25. Wes case referred to medical examiner?  XXI Yes 2 □ No  127. Manner of Death  288. De	© Inpatient 2 □ ER/Out			fome 5 Resi		
27. Manner of Death  1 Naturet 5 Pending (M  28a. De (M  27. Manner of Death  28a. De (M  28b. De (M	te of Injury lonth, Day Year)	jury M	c. Injury at Work? 1 Yes 2 No	280. Describe	how injury occur	red
27. Manner of Death  1 Naturet  1	ace of Injury - At home, fer ilding, etc. (Specify)	m, street, fectory,	office	28f. Location (: City or Tox		per or Rural Routa Number,
29e. Certifier 1 Certifying Physician: To (Check only Medical Examiner: On the	the best of my knowledge, a basis of examinetion and anner stated.	deeth occurred et /or investigation, in	the time, date and plece my opinion, deeth occu	o, end due to the arred at the time,	cause(s) and mi date end place,	anner es stated. end due to the cause(s)
29b. Signatify and title of certifier	0	29c. l	License number		29d. Dale signe	d (Month, Day, Year)
Man cope	W		OCME		JULY	5, 1999
30. Name and address of person who completed on	ause of death (Item 23a) (		t, Baltimore	e, Maryl	and 212	
State Registrar 31. Descripted (Ments, Day, Year) 32	. Registrar's Signeture	books		4		1.54



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death DAVIS, JR. MSEPH 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea BALHNICE VINCENT If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 108 M 2□ F 16-3183 **Uauel Residence of Decedent** 10b. County 10c. City, Town or Location 10d. Inside City Limits BALHMORE 18 Pes 2 No Harylow 203 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? 6618 21211 U513 INCENT 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yea or No-If Yea, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent'a Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) RESIDENTIAL 12 the grade 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) SR. JUS EPL L. DAVIS 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21218 2864 Baltinon, Harylons HAVTUYD ROAD Annelte 20b. Place of Disposition (Nem of cemetery, cremetory or other p 20c. Location - City or Town, State 20a. Method of Disposition 12 Burial 2 Cremetion 3 Removel from State BALLINGA, 4 □ Donation 5 □ Other (Specify) Cameter 22. Name and Address of Facility CHATMAN - April First Hang 21. Signature of Funeral Service Licensee Both neve ICEISTEN 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Carcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Wes an eutopsy performed? 2 No 1 Yea 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Director

by

Completed

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer death w Department of Heelth and Mental Hygiens. Important: if them 27 is marked other than "natural", or thems 23a, any Injury or other treumatic event, the Medical Estatement 23a, any Injury or other treumatic event, the Medical Estatement 23a.

Baitimore, Maryland 21215-0020

Records, P.O. Box 68760

Division of Vital

Examiner

ettending physician and for usa es the burlel-transit Physician/Medical à Completed Be Medical Certification: To

signed by t d be detect certificete or Attending Physicien: this After ne Hospital or Attending in 24 hours efter deeth. the Funeral Director: Afte pletely filled in by the fun.

To the Hosp within 24 ho To the Fune completely fi (Check only one)

27. Manner of Death

1 Netural
2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

31. Date filed (Month, Day, Year)

Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28a. Date of Injury (Month, Day Year)

29c. License number 50242

28c. Injury at Work?

1 Yes 2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mcchyment M.D 201

University

28d. Describe how injury occurred

21218 Balt. MA

State Registrar

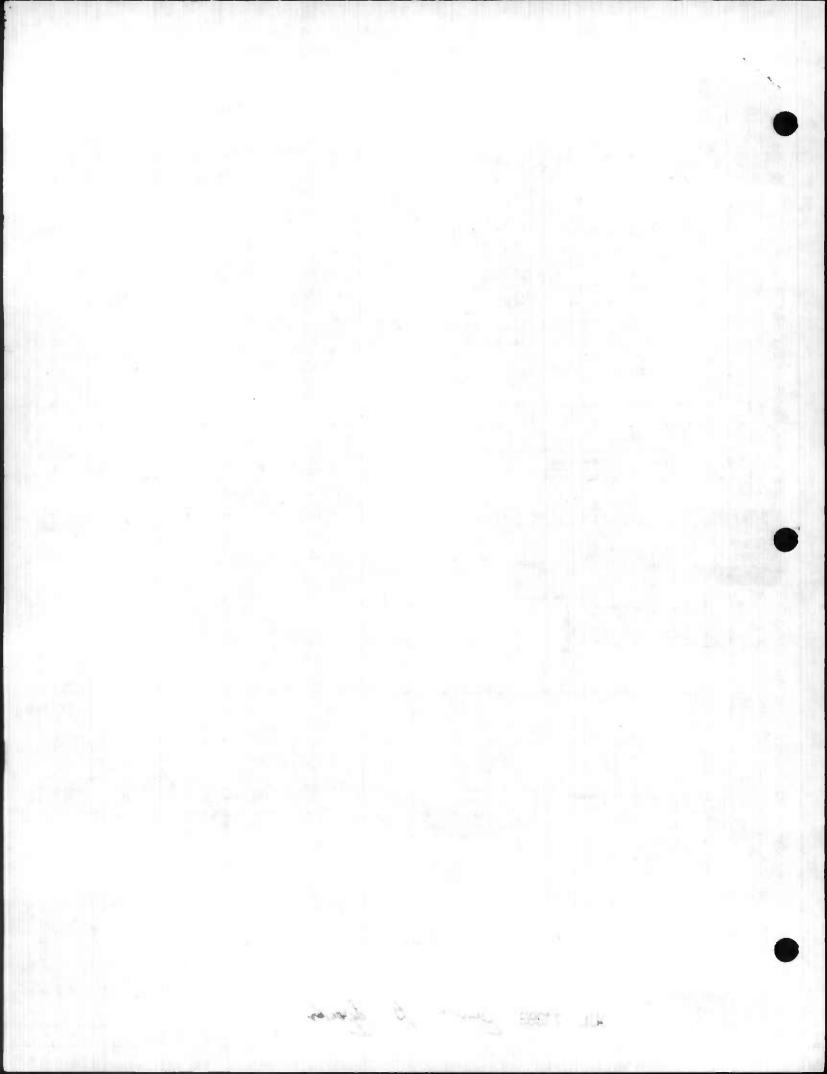
5 Pending

investigation 6 Could not be

32. Registrar'a Signeture

28b. Time of

28e. Place of Injury - At home, term, street, fectory, office building, etc. (Specify)



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Yaar **Physician** Month LINDA MARIE DILL 29 1999 6:09PM JUNE /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore County Gilchrist Center 7. Age (In yrs. last birthday) If Undar 1 Year If Under 24 Hrs. 5. Social Sacurity Number Birthpiaca (State or Foreign Country) **Funeral** 1□M 2√F Days Yrs. Director Feb. 7, 1947 Maryland 212-52-8845 the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Baltimore mant be notified Maryland Baltimore County 1 Yesx X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö USA items 23a 21128 5 Flintlock Court 12. Was Decedent Evar In U,S. Armed Forces? Was Dacedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puarto Ricen, atc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 Never Married XX Married "naturel", or 1 ☐ Yes X No Specify Specify: White by 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Spacify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Security Adm. Industrial Coder 12 yrs. 17. Father's Name (First, Middle, Last) N/A permit. Pages 1 and 2 should be filed Department of Heelth and Mental Hygi Important: If Item 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) Wilbur E. Dearholt Hedwig Ida Colofen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Dill 5 Flintlock Court Perry Hall, Maryland 21128 20b. Place of Disposition (Name of cametery, crematory or other place) Date Date 20c. Location - City or Town, State 20e. Method of Disposition W Buriel 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gardens 7-3-99 Belair, Maryland 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Approximata Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) LeiomyosArcoma 14 years Examiner Due to (or as a consequenca of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai the Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed's 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 405 pice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death I or Attending Plater death. 28d. Describe how Injury occurred Certification: 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suiclde 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end placa, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

within 2

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

6701

who completed cause of down (nem 23a) (Type, Print)

6-BMC

29c. Licensa number

29d. Date signed (Month, Day, Year)

July 1, 1999

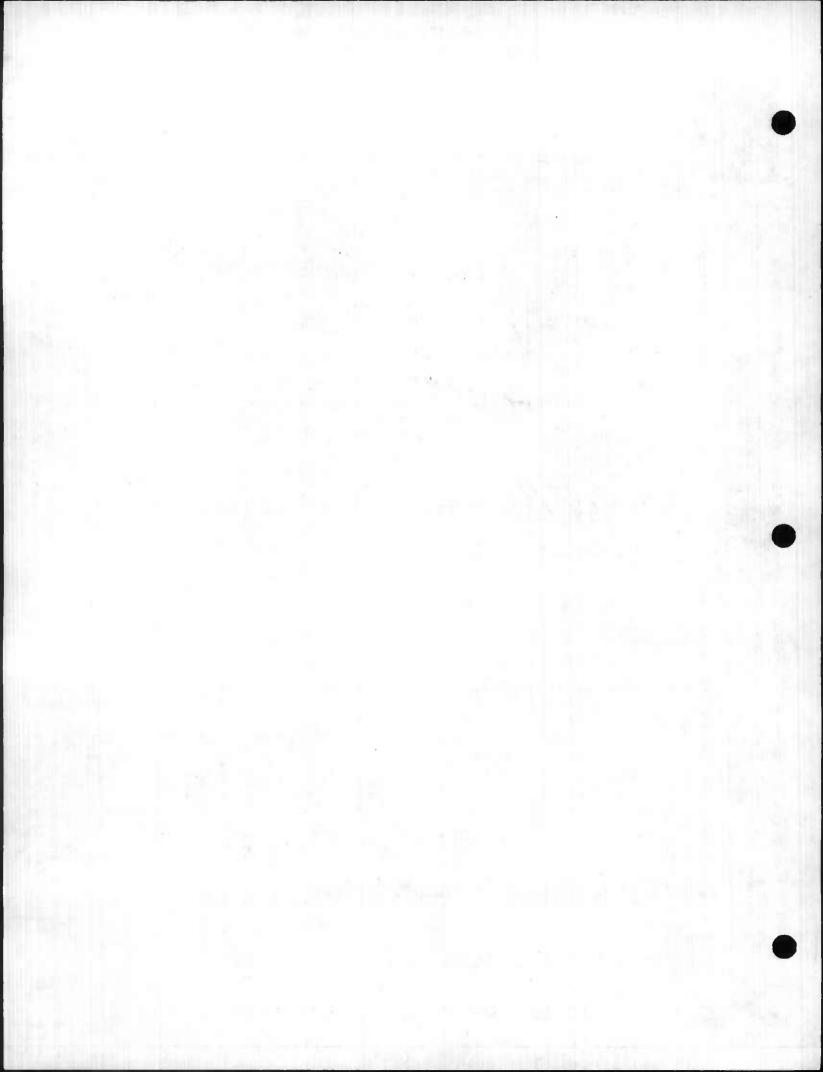
St. BMto, md 21216

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	/Medical	Terry						4h Chi Taua	JUNE	19, 199		0226 AM	
	Examiner	4a Facility Nama (// #295 SO	UTH OF R		r)			CHEVERI	or Location of Dea	,		EORGES	
	Funeral Director	5. Social Sacurity Nunknown	1	Sex 7. /	Age (In yrs. I	last birthday,	If Under 1 Yeer Months Days		lin. (Month, L		9. Birthpi Coun	lace (Stata or Foreign try)	
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	£ 88 6	10e. Street and Nur					10f. Zip Code			10g. Citizen of V	Vhat Coun	Ary?	
	s 23s number						33860			unknown	nknown 14. Race - American Indian,		
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Maryland 21215-0020	ad within 72 ho ygiens. wr then "neturn f, the Medical.]	(Spec	15. Decedant's Edify only highest grandary (0-12)	ducation ide completed) College (1-40	r 5+)		dent's Usual Occup kind of work dona DO NOT use retire	oation during most of a d)	working	16b. Kind of Bu	usinass/Ind	lustry	
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Z	2 should and Marriage marriage aurmatic	19a. Informant's Ne	me/Ralationship (	Type, Print)		19b. Maili	ing Address (Street			ber, City or Town,	Stata, Zio	Code)	
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	within 2 To the comple	29b. Signeture end	title of certifiar				29c. Licens			29d. Data signe		Same i	
		30. Nama and addre	ss of wrson who	completed cause of			Print)	C.M.E				1999	
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State of Maryland / Department of Health and Mental Hygiene 0.0

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SH		1806 Edmond							Baltin				I/A	
	Funeral Director	5. Social Security Numb	0er(/4//C 6. Se	X 7. A 9 M 2□ F	ige (In yrs. 62	last birthday) Yrs.	Month:	er 1 Yea Days		Min. 8. C	Dete of Birth Month, Dev /23/	Year)	9. Birthp Coun	lace (State or Foreign ltry) Carolina
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Manda	uned sho	MD	N/Z	A	100.01	Balt		re						0d. Inside City Limits  Y☐ Yes 2☐ No
2-0020	tems 23a or 25a-7 show	10e. Street and Number		on Avenu	ıe		10f. Z	ip Code 2	1.223			10g. Citizen of V	S · A ·	•
ar death	r tems 234 siner must	11. Merital Status		12. Was Deceden Armed Forces	?	,S. 13.	Was Dec	edent of ecify Cu	Hispanic Origir ban, Mexican, I	n? (Specify Puerto Rica	Yes or No- n, etc.)	14. Rac Bled	e - Americ ck, White,	
A STORE	raf., or	1 Never Married 3 Widowed 4		1 Yes 20 If Yes, Give Year or Dates					Specify:			Specify	Specify: Black	
107 h	ygiene. or than "natural", t, the Wasselleri Completed by	(Specify o	Decedent's Edu only highest grad	le completed)		16a. Deced (Give life.	dent's Us kind of w	ual Occu ork done use retir	upation e during most o red)	of working		16b. Kind of Bu	usiness/Ind	dustry
A within	giene.	Elementary/Seconda	ry (0-12)	College (1-4or	5+)						-			
id be fled	H off	17. Father's Name (First Julius		.s						Name (Fir bell		Maiden Sumen ins	10)	
Maryiand 21215-0020	DE E	19a. Informent's Neme. Sadie Ta		ype, Print)								or, City or Town, alto.,		Code) 21.223
Pages 1 ar	if item 27 or other tr	20a. Method of Disposit	remetion 3 🗆 f	Removel from State		Place of Dispo			lace)	D	ete	20c. Location -	City or To	wn, Stete
Dailinore,	Department Important: I eny fijury o	4 Donetion 5 21. Signature of Funera		_	ME?	22	1600	L I	ress of Facility BERTY RE, MA	HOW	ELL HTS	BALTIM FUNERA AVENUE 21207	L HC	, MD OME
	hysician	23a. Pert1. Enter the d shock, or heart fe		lications that ceus ne cause on each	d the deat line.	h. Do not ent	er the m	ode of dy	ying, such es ca	ardiac or res	spiratory ar	rest,		Approximata Interval Between Onset and Death
	Medical xaminer	Immediate Ceuse (Fine disease or condition resulting in death)	el .	Arteriosclerotic Cardiovascular Dis						Disea	se			
D	in a recipient			h	Due to (c	Due to (or as a consequence of):								
iceta be axacute	physician and s the buriat-transit odical Examiner	Sequentially list conditi if any, leading to imme- cause. Enter Underlyin Cause (Disease or injur	ons, diete	о.	Due to (o	er es a conseq	juence of	):				2		
	7	that initieted events resulting in death) Last		d	Due to (o	r as e conseq	uence of	):					i	
death cen	attending for use a	Deat II. Other steelilises	d and distance and	and the state of t		- dat t			tion to Boat		cor pid		1 -	the same of death
hat the	by th	Part II. Other significan	i conditions co	ntributing to death	out not res	uning in the u	noenying	cause g	oven in Part I.					the cause of death? bably 4 XUnknow
he law requires the	D 86		700		_						24a. Was o	en eutopsy med?	av	era autopsy findings aileble prior to mpletion of cause
	hes be 2 s											ection es 200 No	of	death?
	director, pa	25. Was case referred to	lo medical						26. Place o	f Deeth (Ch				
Physician:	To E	examiner? XXYes 2 No	1	Hospital:	ient 2 🗆	ER/Outpatier	nt 3 🗆 C	O AOC	ther: 4 Nurs	ing Home	5 A Resid	lence 8 🗆 Oth	er (Specif	y)
	death. ctor: After th y the funeral	27. Menner of Death  †\( \sum_{\text{Netural}} \)  2 \( \sum_{\text{Accident}} \)	Pending investigation	28a. Date of In (Month, D	ury ay Year)	28b. Time of Injury	M	28c. Inj W 1[	uryat ork? ⊒Yes 2 ⊒No		Describe h	now injury occur	red	
5 8	Mreci in by	3 ☐ Suicide 6 4 ☐ Homicide									281. Location (Street and Number or Rurel Route Number, City or Town, State)			
Hospita	n 24 hours and Funeral Chieftaly filled edical Ce			sician: To the besi ner: On the basis and manner s	of examina									

To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun

. Was case referre	ed to medical						26. Place of De	eeth (Check only one)
examiner?	lo	Hospital:	ER/Outpatient	atient 3 DOA Other: 4 Nurs			Home 5 X Residence 8 ☐Other (Specify)	
Menner of Death    Netural   Accident	5 Pending investigation	28a.	Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286.	Place of Injury - At to building, etc. (Speci	nome, ferm, stree	et, facto	ory, of	fice	28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one)

O.C.M.E.

29b. Signeture and title of certifier

29c. License number 29d. Dete signed (Month, Dey, Year)

July 04, 1999

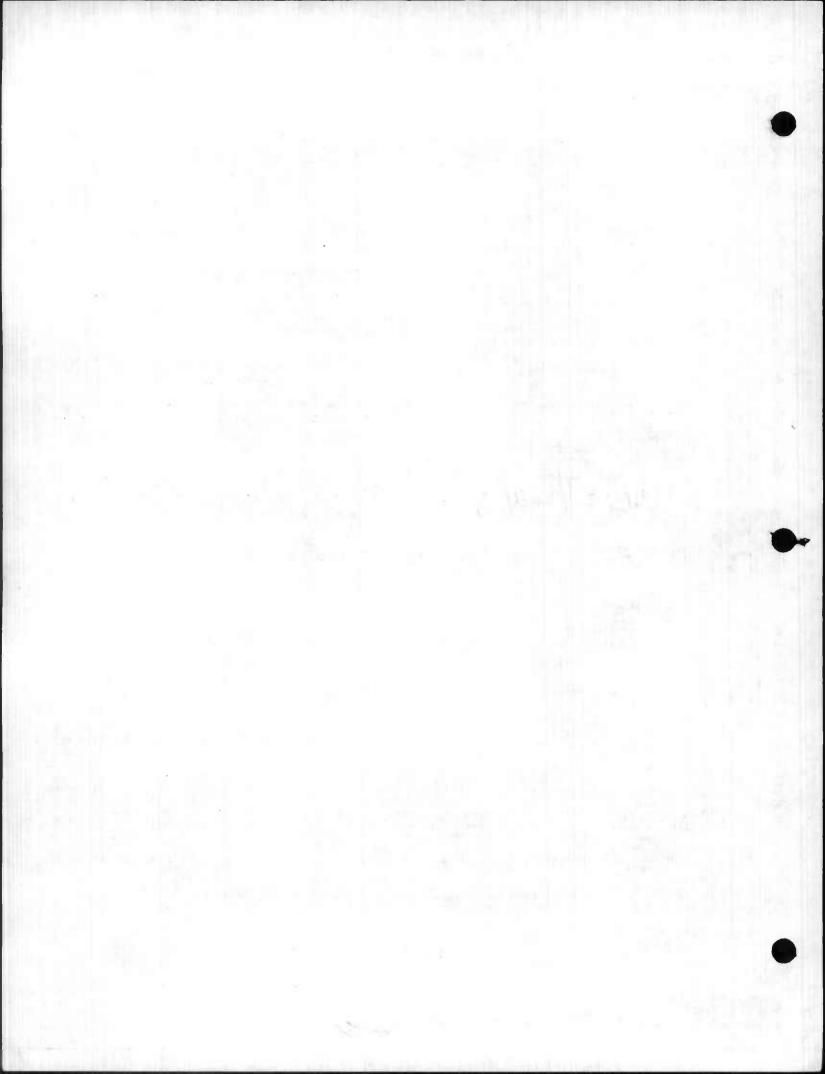
30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

Stephen Radentz, M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) State Registrar

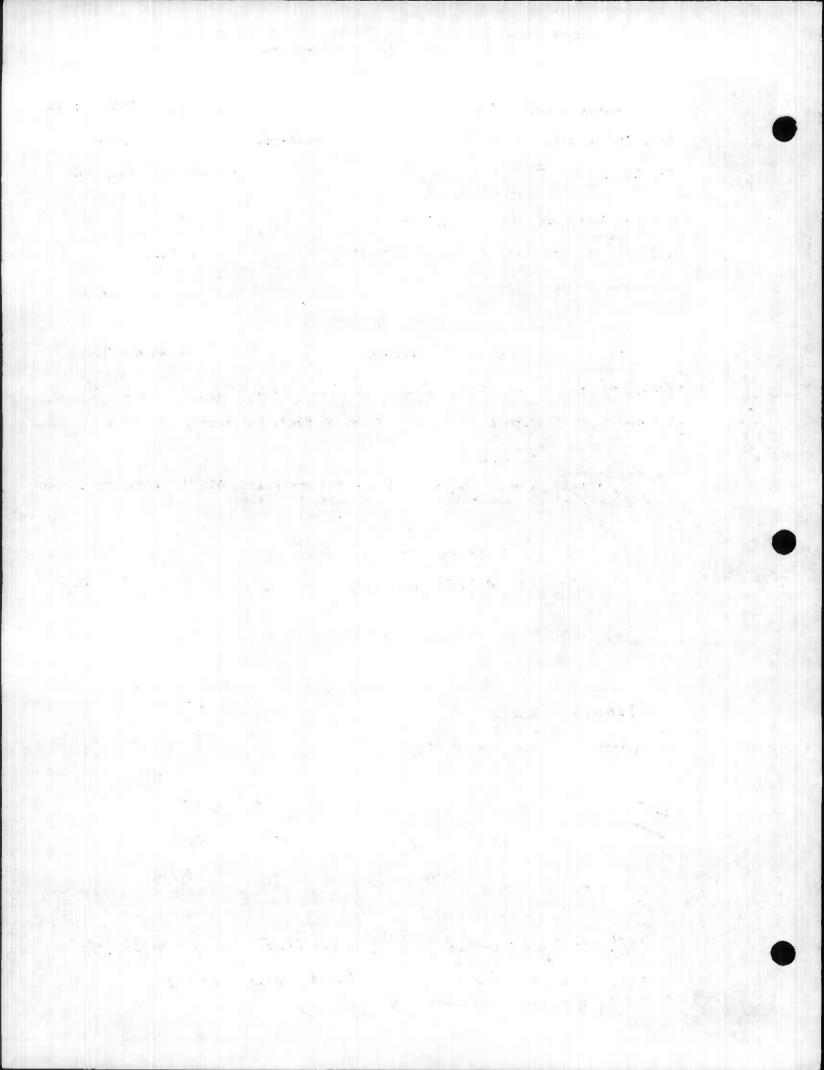
32. Registrar's Signeture



### Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 2 | 2 6 0

				Cei	unicate	of D	eatn	R	eg. No.				
	1. Decedent'a Nama (First, Middl	e, Last)						2. Date of Deal Month	th Day	Year	3. Tima of Death		
sician edical	Henry	Doelle, J	r.					June	12	1999	2:59am		
miner	4a Facility Name (If not Institution	n, give street and num	ber)			4b	. City, Town, or L	ocation of Death	4c. Co	unty of Death			
	1125 Old East	ern Avenue	#D				Baltimor			1timore			
ral	5. Social Security Number	6. Sex 7	. Age (In yrs.			Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec. 22	Year)	9. Birthpl Coun	laca (Stata or Foreig try)		
tor	213-26-1160	TUALM ZUIF	6	9 Yrs.				Dec. 22	, 192	9 Mary	Land		
	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10	Od. Inside City Limite		
7											1 ☐ Yes 2 N N		
Director	Maryland Baltin	more	В	altimo:	re 10f. Zip C	ande.		1	10g. Citizan of What Country?				
늄	1125 Old East	orn Azonuo			212				U.S.A		.,,		
by Funeral Director	11. Marital Status	12. Was Deced	lant Ever in U	S 13 1			nanic Origin? (Si			Raca - America	an Indian.		
F	1 Never Married 2 Marri	Armed Fore	ces?	, , , , ,	If Yas, apecif	y Cuban	Mexican, Puart	pecify Yes or No- Rican, etc.)		Black, White,	etc.		
þ	3 ☐ Widowed 4 ☐ Divorced	If Yes Give	)		1 ☐ Yes 2	No No	Specify:		Sp	ecity: wh:	ite		
	15. Deceder	t'a Education		16a. Dece	dent's Usual	Occupat	ion		16b. Kind	of Business/Inc	lustry		
Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed)  College (1-	Aor E ()	(Give	kind of work DO NOT use	done du retired)	ring most of wor	king					
E	12	O O	40( 3+)	Pair	nter				Resi	dent Ho	ousing		
Be C	17. Father's Name (First, Middle,	Last)					18. Mother's Nan	ne (First, Middla, I					
ToB	Henry Doelle						Elsie	Mav					
-	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (	Street a		ral Route Number	r, City or To	own, State, Zip	Code)		
	Dolores M. Do	elle/spous	e	7834	Wynbr	ook	Road, B	altimore	. MD	21224			
	20a. Mathod of Disposition		20b. F	Place of Dispo	sition (Name	e of				ion - City or To	wn, Slate		
	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		tate	ombiory, oral	naiory or our	ioi piaco	·						
	21. Signature of Funeral Service		7	22	2. Nama and	Address	of Facility						
og	Rona	ld S. Wade	Dire					rd, 655	W. Ba	1timore	Street		
	238 Cart 1. Enlar the disease, or	Somplications that on	used the deal	b Do not ent	BaLtim Bartha mode	ore,	MD 21	201	rest		Approximate		
	doos, or haart failure. List										Interval Between Onset and Death		
	Immediate Cause (Final	0		. 14			TypeII				×		
	disaasa or condition resulting in daath)	a	many	ath	WWSON	PARSA	7				13 yrs		
<u>•</u>		D	Due to (c	or as a consec	quenca or):		7. 71			101 00			
Examiner		b	Dunta	or as a consec	11705		17pe 21			- 1	1395		
Exa	Sequentially list conditions, it any, laading to immadiata causa. Entar Undarlying Cause (Disease or Injury		Dua to (t	n as a consec	querica orj.								
	that initiated evants	C	Due to (c	or as a conseq	mence of).								
Medical	resulting in death) Last		Dao 10 (c	4 43 4 001130Q	(401104 01).					į			
		d											
Physician/	Part il. Other significant condition	ons contributing to dea	ath but not ras	ulting in the u	ınderiving çaı	use give	n In Part I.	23b. Did to	obacco ua	e contributa to	the cause of deal		
5									1				
E	Taba							1 1	108 ZU		pably 4 Unkno		
	Toballo	abize						1014	98 201		pebly 4 □ Unkno		
by	Tobacco	ande	1.					1 (1-4)	an autopsy		ere autopsy finding		
by	Tobacco	Non con	mplia	nce				24a. Was a	an autopsy	av.			
by	Toballo	Non con	mplia	nce				24a. Was a perfor	an autopsy med?	co	ere autopsy finding allable prior to mpletion of cause death?		
Completed by			mplia	nce			26. Place of Des	perfor	an autopsy med? 'es 2824	co	ere autopsy finding allable prior to mpletion of cause death?		
Be Completed by	25. Was casa referred to medica examination	l Hospital:			nt 3 DOA	A Othe		perfor	an autopsy med? 'es 2 124	avi co of	ere autopsy finding allable prior to mpletion of cause death?		
To Be Completed by	25. Was casa referred to medica examinating 1 ☐ 16s 2 ☐ No 27. Manner of Caath	Hospital: 1 In 28a. Date of	patient 2	ER/Outpatier		4	r: 4 Nursing H	perfor	an autopsy med? 'es 2 Df	avi co of 1 [	ere autopsy finding: allable prior to mpletion of cause death?		
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edical Certification: To Be Completed by	25. Was casa referred to medical examines   2   No    27. Manner of Death   5   Pendir invasti   2   Accidant   3   Suicida   4   Homicide    29a. Certifier (Check only one)   1   Certifyir   2   Medical	Hospital: 1 In Ing	Injury, Day Year) of Injury - At hig, etc. (Speciosest of my knoss of examine	28b. Tima o Injury ome, farm, atr	et 286  - M  reet, factory,  h occurred at vestigation, in	office	at 7 as 2 No	performance that (Check only or	an autopsymed?  les 2004 enca 6 cow injury of the company of the c	avicco of 1 []  Other (Specific courred dumber or Rura dumanar as si aca, and dua to	ere autopsy findings allable prior to mpletion of cause daath?  Yes 22700  Who are not a second or a s		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev EWARN **Physician** JOHN :46PM July third /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. | Months | Deys | Hours | Min. | 5. Social Security Number 219-52-5366 7. Age (In yrs. lest birthday) 6. Sex Birthpleca (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** Months Deys 10XM 20 F Yrs. 50 Director MAY 26,1949 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10e. Stete 10b. County 10d. Inside City Limits MD BALTIMORE 1 Yes 2 No Director DUNDALK 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 7711 MEATH ROAD Norma 23a 21222 U.S.A.

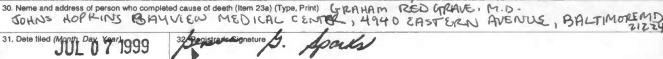
14. Race - American Indien,
Bleck, White, etc. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus hours after 1 Never Merried 2 Merried natural, or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify Specify: WHITE 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry 24 filed within Elementery/Secondery (0-12) College (1-4or 5+) FISHERMAN SHRIMP BOAT 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental JOHN EWARD EVELYN WRIGHT 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) EVELYN WRIGHT- MOTHER or other tra 7711 MEATH ROAD BALTIMORE, MARYLAND 21222 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 7-6-99 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) BALTIMORE-WASHINGTON CREMATORY LAUREL, MARYLAND 22 Name and Address of Fecility BRADLEY-ASHTON-MATTHEWS FUNERAL HOME INC. 21. Signature of Funeral Servica Licensee 2134 WILLOW SPRING ROAD BALTIMORE, MD 21222 the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, sert feiture. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 52PS 15 Examiner Due to (or es e consequence of) Examine The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest Due to (or es e consequence ot): Box 68760. Physician/Medical Due to (or es e consequence ot): P.O. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records. 24b. Were eutopsy findings aveilable prior to completion of cause of deeth? Completed 24a. Wes en autopsy performed? hes page 1 ☐ Yes 2 No 1 Yes 2 No or Attending Physician: Be 25. Wes case reterred to medical 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3 DOA After this 27. Manper of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Neturel deeth. 1 Yes 2 No 2 Accident after deeth Director: 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Nedical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) end menner steted.

**DHMH 16 Rsv 6/95** 

Registrar

29b. Signeture end title of certifier



MD-

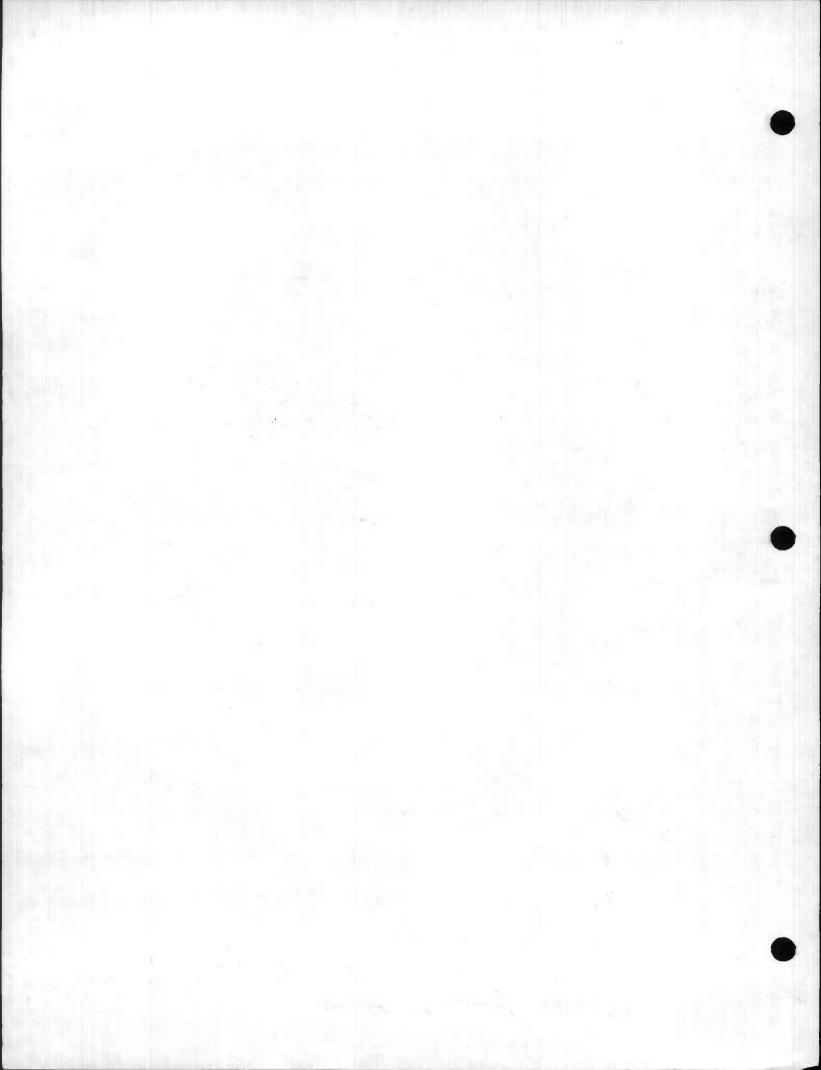
doorles

29c. License number

20314

29d. Dete signed (Month, Dey, Year)

JULY



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Deeth 3. Time of Death **Physician** awrence Feenel 1999 JUI 3nd /Medical 4a. Fecility Name (If not institution, give street end number 4b. City, Town, or Location of Death 4c. County of Death Examiner Bultimure n/a If Under 24 Hrs. Hours Min. 5. Sociel Security Number If Undar 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1X) M 2 F 214-01-4704 Yrs Director 84 Sept. 18 1914 Maryland Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location rel', or items 23a or 28a-f ahow Examiner must be notified at 10d. Inside City Limits Director Md. Baltimore 1 Yes 2 No n/a the 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1533 Byrd Street 21230 USA Funeral 12. Was Decedent Evar In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yaar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify. þ Specify: white 3X Widowed 4 □ Divorced "naturel", Completed traumatic event, the Medical 16e. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Business/Industry other than Elamentary/Secondary (0-12) College (1-4or 5+) Maryland Glass 12 Chief Operator 0 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meidan Sumeme) Be 12 should be finance and Mental Fire marked ott J. Thomas Feehelv Catherine V. Tuohy 2 19a. Informent's Nama/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a Lawrence L. Feehely, Jr. (Son) 128 Bryans Channel Way, Queenstown, Md. 21653 20b. Piece of Disposition (Name of cemetery, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete 1 Dauriel 2 Cremation 3 Removal from State 6 permit. Page Department of Important: If any Injury or 5 Other (Specify) 4 Donation Glen Haven Memorial Park 7/7/99 Glen Burnie, Md. 21. Signature of Funaral Service Licansed 22. Name and Address of Fecility McCully-Polyniak Funeral Home P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast. 130 E. Fort Ave. Baltimore, Md. 21230 shock, or heer failure. List only one ceuse on each line. Approximete Interval Batween Onset end Death **Physician** /Medical Immediata Ceusa (Final disaasa or condition resulting in deeth) Meningioma Examiner Dua to (or as a consequence of): Examiner Sequantially list conditions, if eny, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initiated events resulting in death) Lest and Dua to (or as a consequence of): physician a the burial-Box 68760 Physician/Medical Dua to (or as a consequenca of): for us signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. P.0. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Thurstrown Records, by Atrial Fibrillation Completed 24e. Was en autopsy performed? 24b. Wera autopsy findings available prior to completion of cause of daeth? page 1□ Yes 2□No 1 ☐ Yas 2 ☐ No-Division of Vital 25. Was case referred to medical examinar? Be 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a, Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Attending 1 DNatural 5 Panding death. 1 Yes 2 No Investigation or Attend after death Director: / 2 Accident 6 Could not be 28f. Location (Streat end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Pleca of Injury - At home, farm, straat, factory, offica building, atc. (Specify) 4 Homicida To the Hospital within 24 hours a To the Funeral I completely filled 1 Certifying Phyaician: To the best of my knowledge, deeth occurred at tha time, date end plece, and due to the causa(s) and mannar es atated. 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, daath occurred at tha time, data and place, and due to the causa(s) and menner stated. 29a. Certifier Medical 29b. Signatura and title of certifian 29c. License number 29d. Data signed (Month, Dey, Year) eleted cause of daeth (Item 23a) (Type, Print) I Place Bulhmore, 31. Date filed (Month, Day,

Registrar

State

MITTER ENDINE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** CHRISTIAN ·AM FISCH BECK 1999 YILL 02=17An /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Aug. 22, 1952 ER FALLSION GENERAL HOSPITAL HARFOND 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** MM 2DF 217-62-4712 46 Director Maryland Usual Residence of Decedent the Merylenc 10c. City, Town or Location 10a State 10h Counts 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f shot other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Belcamp Directo Maryland Harkord 10e. Sfreef and Number 10f. Zip Code 10g. Citizen of What Country? 1278 Allison Court 21017 U.S.A. Funeral death 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Bleck, White, etc. 11. Marital Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) permit. Peges 1 and 2 should be filed within 72 hours after 0 Deperment of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural, or item any injury or other traumatic event, the Medical Evantina. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: altimore, Maryland 21215-0020 Specify: White λq 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manager Retail Paint 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Christian William Fischbeck Sara Rudolph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Linda L. Fischbeck 1278 Allison Court, Belcamp, MD 21017 (wife) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Joseph Church Cem. 7/6/99 Baltimore, Maryland 22. Name and Address of Facility
Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licensee male T. Zavoyva 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, a mplications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical ASCUD Examiner Due to (or as a consequence of). Examiner physician end s the burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lasf Due to (or as a consequence of): Box 68760. Physician/Medical es the Due to (or as a consequence of) 950 ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown signed by Division of Vital Records. þ 24e. Was en eutopsy performed? 24b. Were autopsy tindings available prior to Completed completion of cause of death? certificate has 1 Yes 2 KNo 1 Yes 2 No 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 No 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred Certification: 28c. Injury at Work? To the Mospital or Attending I within 24 hours eiter deeth.

To the Funeral Director: After 5 Pending Investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Certifier Medical

29c. License number

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29d. Date signed (Month, Dey, Year)

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31. Date filed (Month, Dey, Yeer) State Registra

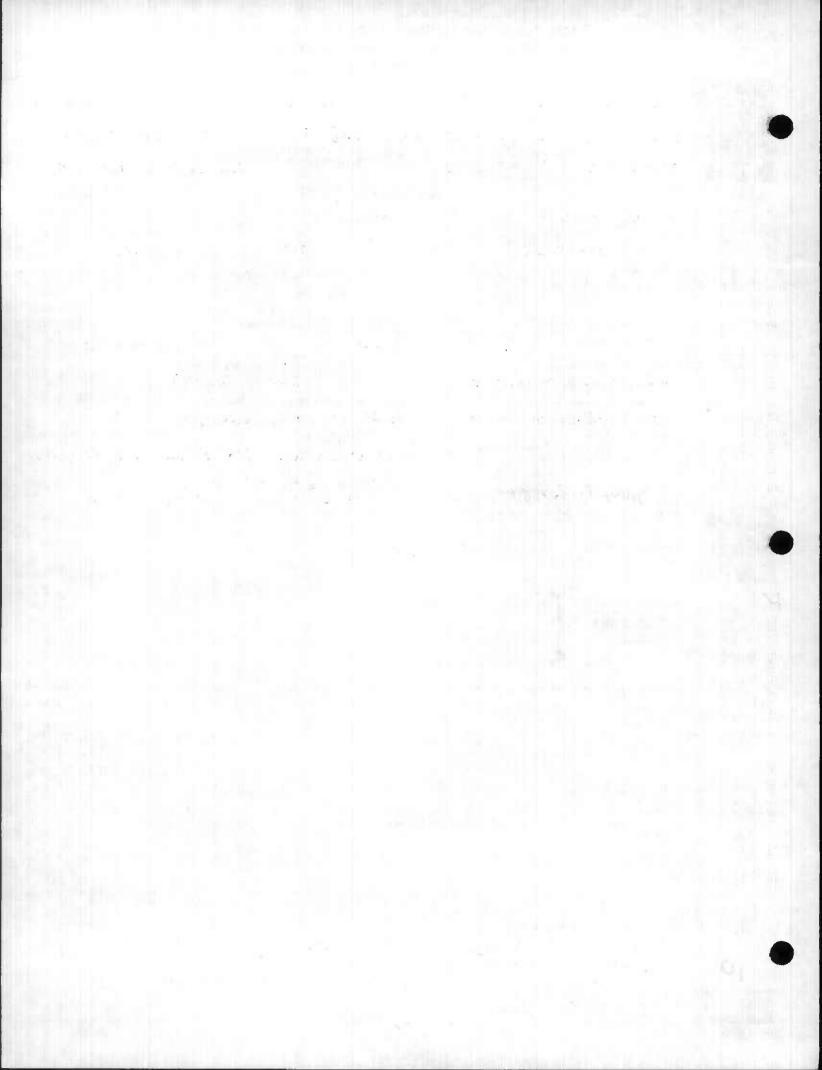
29b. Signature and title of certifier

NASHU

32. Registrar's Signeture 071999

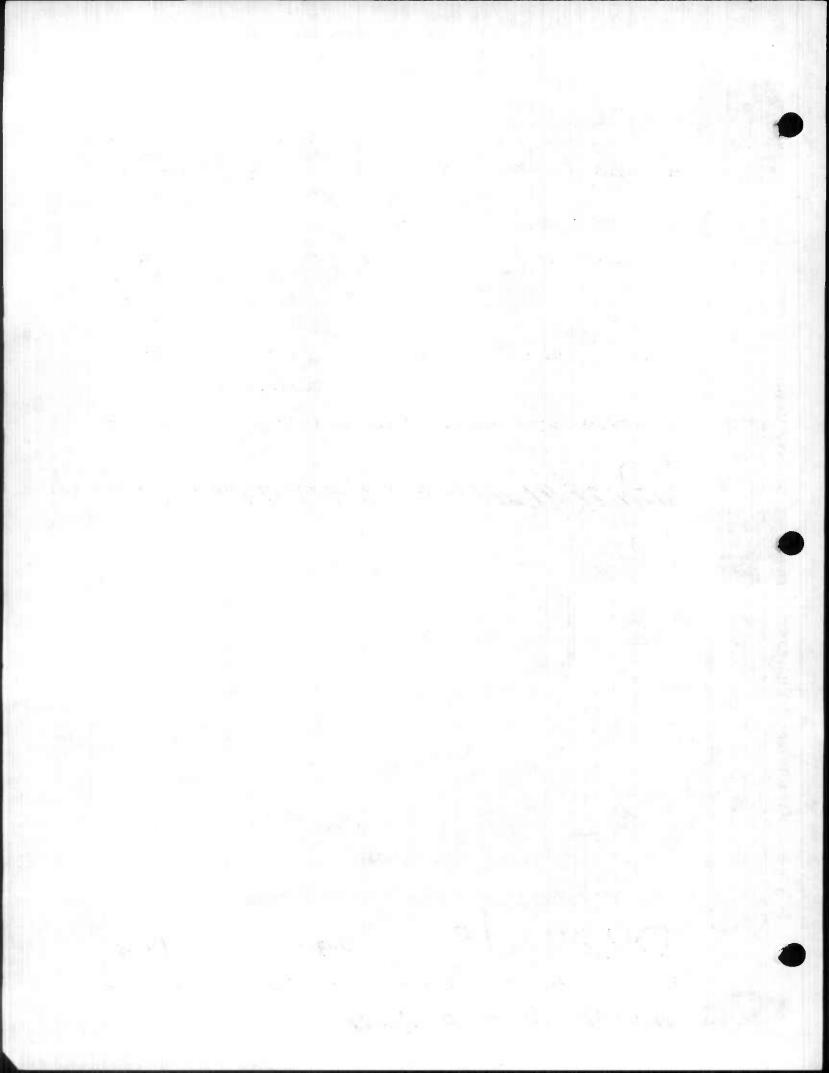
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importants if them 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinations to the routing at another.				1	Meiling Address (Street					
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		30. Name and address of person who co	npleted cause of dea	th (Item 23a) (T		2.00		1	11	
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#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Edward Marion Ford 1999 5014 6:10am 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Rosedale Baltimore Franklin Square Hospital center If Under 24 Hrs. 8. Date of Birth Hours Min. May 27, 1928 9. Birthplece (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 5. Social Security Number Months Days XXM 2□ F 217-24-3853 Yrs Usual Residenca of Decedent 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes ZNo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 F Eddy Stone Place 21221 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ② No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, 11. Maritei Status Bleck, White, etc. 1 Never Merried 2 Married if Yes, Give Yeer or Detes: 1 Yes 2€ No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grede completed) Maryland Port Coilege (1-4or 5+) Elementary/Secondary (0-12) Authority Maintenance 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Samuel E. Ford Ellice Lee Oakley 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) Inez Ewing 8245 Peach Orchard Road Dundalk, Maryland 21222 Sister 20b. Piace of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Buriai 2 Cremation 3 Removal from State Hilltop Service Corp. 7/6/1999 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licansee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland Inc. 21222 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) a Retropertioneal Hemorrhae 15 hours Due to (or es a consequença of): b. Abdominal Aortic Aneurysm 15 hours Due to (or as a consequence of): Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 2000 3 Probably 4 Unknown

**Physician** /Medical **Examiner** 

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Medical

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P.O. Box 68760.

Division of Vital Records,

**Physician** 

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7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Exerciting must be notified.

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Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Physician/Medical

Severe Chronic Ostructive Pulmonary Disease

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Cardionyopathy

25. Wes case referred to medical examiner? 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residenca 8 Other (Specify) Impatient 2 ER/Outpatient 3 DOA Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Yes 2 No Investigation

3 Suicide 4 Homicide 29a. Certifier

1 Yes 2

27. Manner of Deeth

1 Anaturai 2 Accident

6 Could not be determined 28e. Pieca of Injury - At home, ferm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

1 Yes 2 No

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date end piaca, and due to the cause(s) and menner es stated.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

RD 1917 83

DR Kevin Brewster

9000 Franklin Square Drive baltimore Maryland 21237

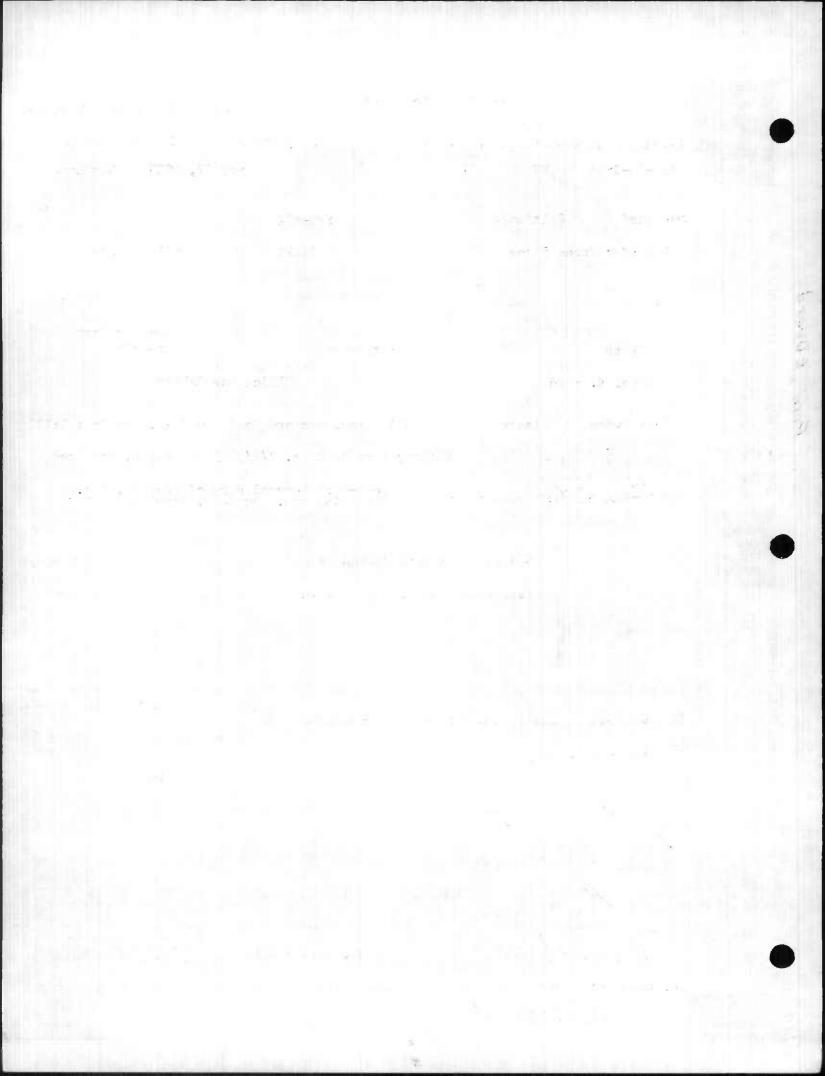
31. Date filed (Month, Day, Year) State

JUL 07 1999

32. Registrar's Signeture General

**DHMH 16 Rev 6/95** 

Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Nama (First, Middla, Last) Month Z 9 **Physician** JUNE 1999 10 pm Paul Frev /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, giva straat and number) 4c. County of Deeth Examiner Baltimore N/A St. Agnes Hospital If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5-5-1900 Birthplaca (State or Foreign Country) Ohlo 5. Social Security Number 7. Aga (In yrs. lest birthday) **Funeral** 1□M 2□F Yrs Director 99 272-03-6977 Usuel Rasidence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Director Catonsville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 21228 S. A. 711 Maiden Choice Lane Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) Rece - American Indien, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐XNo If Yes, Give Yeer or Datas: 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐xNo Specify: Specify: White ρ 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade complated) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Automobile Parts Service 12 18. Mother's Neme (First, Middle, Meiden Sumame) 17. Fether's Neme (First, Middle, Last) Anna Zbinden Rudolph Frey 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 200 Hemlock Drive, S. E. Blacksburgh, Va. 24060 Mr. James Hardell (Nephew) 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Data 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Ramovel from State 7-6-99 Towson, Maryland 21204 Hilltop Service Corp. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Jallace S.B Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the daath. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heert failure. List only one ceuse on eech line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disaese or condition resulting In deeth) **Examiner** Due to (or as a consequence of) Examiner Normon A Sequentielly list conditions, if any, leading to immediate ceuse. Enter Undarlying Cause (Diseese or Injury that initiated events rasulting in death) Last Due to (or as e consequence of): Physician/Medical Dua to (or as e consequence of): For Colon Day KESELTION 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown 2 24b. Were autopsy findings evaileble prior to completion of ceuse of death? Completed 24e. Wes en autopsy performed? 2 02No 1 Yes 1 ☐ Yes 2 No 25. Wes cese referred to medical axaminar? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 phopatient 2 □ ER/Outpetient 3 □ DOA 10 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending invastigation 1 ☐ Yas 2 ☐ No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Sulcide 6 Could not be detarmined 28e. Plece of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred et the tima, dete end place, and due to the ceuse(s) end manner as steled. 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the ceuse(s) and menner stated. edicai 29a. Certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

**DHMH 16 Rev 6/95** 

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death

altimore, Maryland 21215-0020

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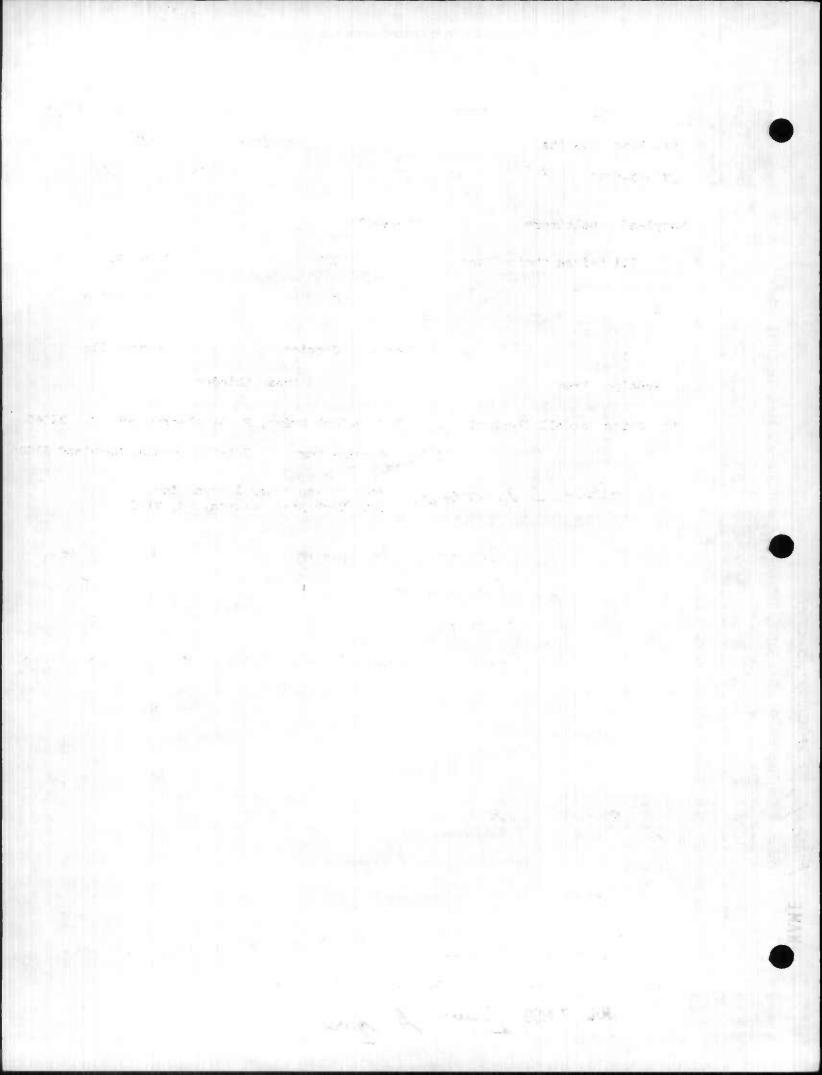
32. Registrer's Signature

30. Neme and address of person who completed/cause of deeth (Item 23e) (Type, Print)

G. Sparke

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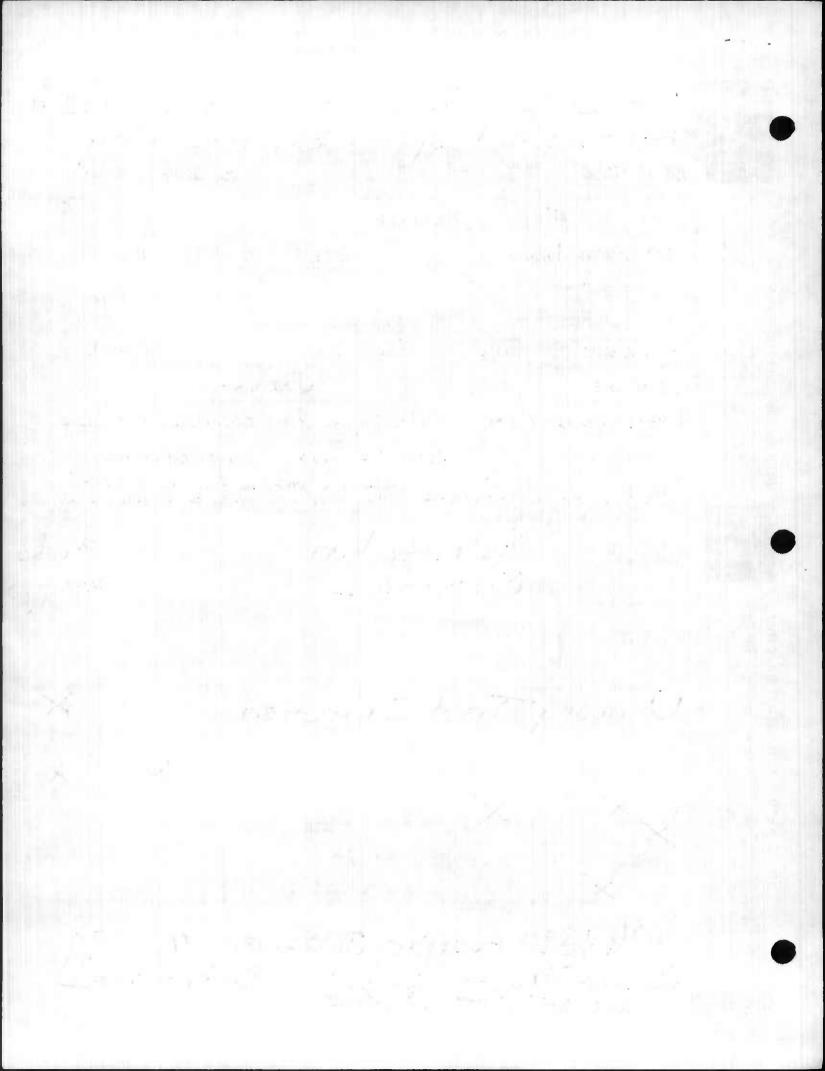


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Day **Physician** 50 9 9 2 /Medical 4c. County of Deal b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) Examiner 8. Date of Birth (Month, Dey, Year) 266 2700 noc 0 of Under 24 Hrs. If Under 1 Year 7. Age (In yrs. lest 9. Birthplac 5. Social Security Number 6. Sex (Stete or Foreign hirthday) **Funeral** Months Days Hours 1 M 2 F 218-18-7660 83 Director Usual Residence of Decedent death with the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at BALTIMORE 1 Yes 2 No NIA mp Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1700 THOMAS 21216 ENUE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race Race - American Indian, Black, White, etc. 11 Marital Status hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0020 Specify. Specify: BLACK þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life\_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Hygiene. Eiementary/Secondary (0-12) College (1-4or 5+) LOTHING DEAMSTRESS 1TH GRADE NA permit. Pages 1 end 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 Is marked other I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be JOSEPHINE LEE MHOL 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) BALTIMORE, MO. 21216 KOBERT GREGORY 1100 1 HOMAS AUE, 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 20a. Method of Disposition Date cametery, cremetory or other placa) 1 Burial 2 □ Cremation 3 Removal from State 7-6-99 BALTO. MO 4 ☐ Donation 5 ☐ Other (Specify) RBUTUS EMEMERY 21. Signature of Funeral \$ 22. Name and Address of Facility eny in VAUGHN C. GREENE FUNERAL SERVICE se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter shock, or he **Physician** /Medical Immediate Ceuse (Fine disease or condition resulting in death) Examiner Due to (or es Examiner requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): and attending physician for use es the bune P.O. Box 68760. Physician/Medical Due to (or as a consequence of): Part Ja Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uas contributs to the cause of death? the been signed by t should be detech Unknown 1 Yss 2 No 3 Probably by Records. 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? The law page 2 s 1 ☐ Yes 1 Yes certificate Division of Vital After this certifical funeral director, Hospital or Attending Physician: Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 Yes 2 ER/Outpatient 3 DOA 27. Manner of Deeth Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 3 Sulcide 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) n by To the Hospins.
within 24 hours after
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2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, dete end placa, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Dey, Year) 29c. License number

d cause of death (Item Ala) (Type, Pi

State Registrar 31. Date filed (Month,

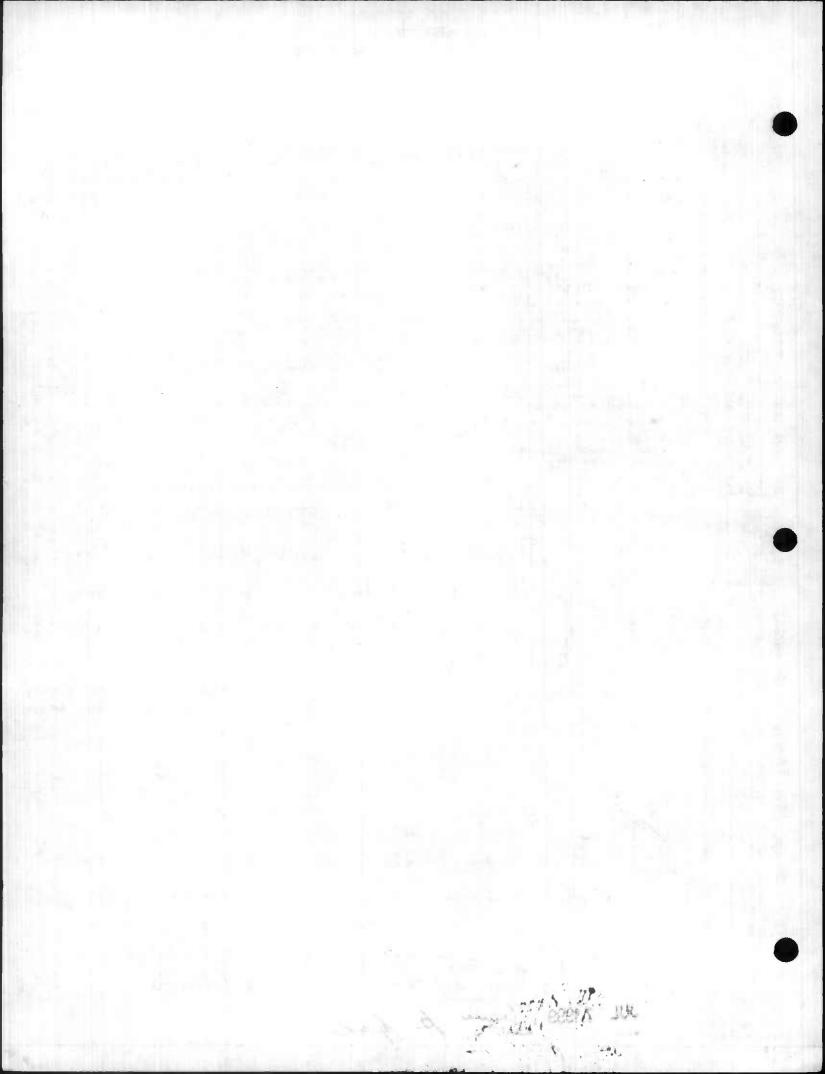


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State of Maryland / Department of Health and Mental Hygiene

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	/Medical Examiner	Iner	Immediata Causa (Final disaasa or condition resulting in death)		GESTIV Due to (or as 20SC LEI	0.00000011	anno offi			LURE	DIS	GEAS	E   0	year
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29c. Licansa number 0 4:0356

29d. Data signed (Month, Day, Year)

29b. Signature and title of certifier

Warrand Well Specialist

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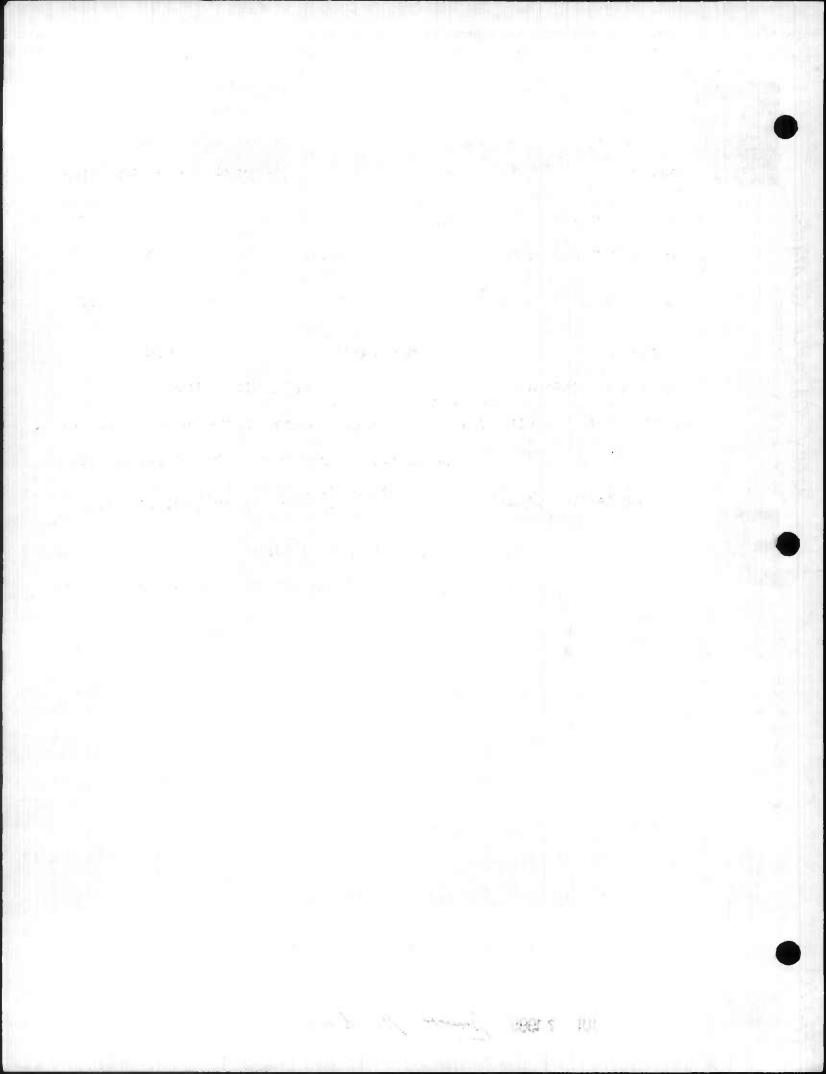
3Q. Nema end address of person who completed causa of death (Item 23a) (Type, Print)

WENEUSA NAVARRO ND 100H - Broadway, Baltimore, Haryland 2/23/

31. Data tilled (Month, Day, Year)

32. Ragistrar's Signatura

State Registrar

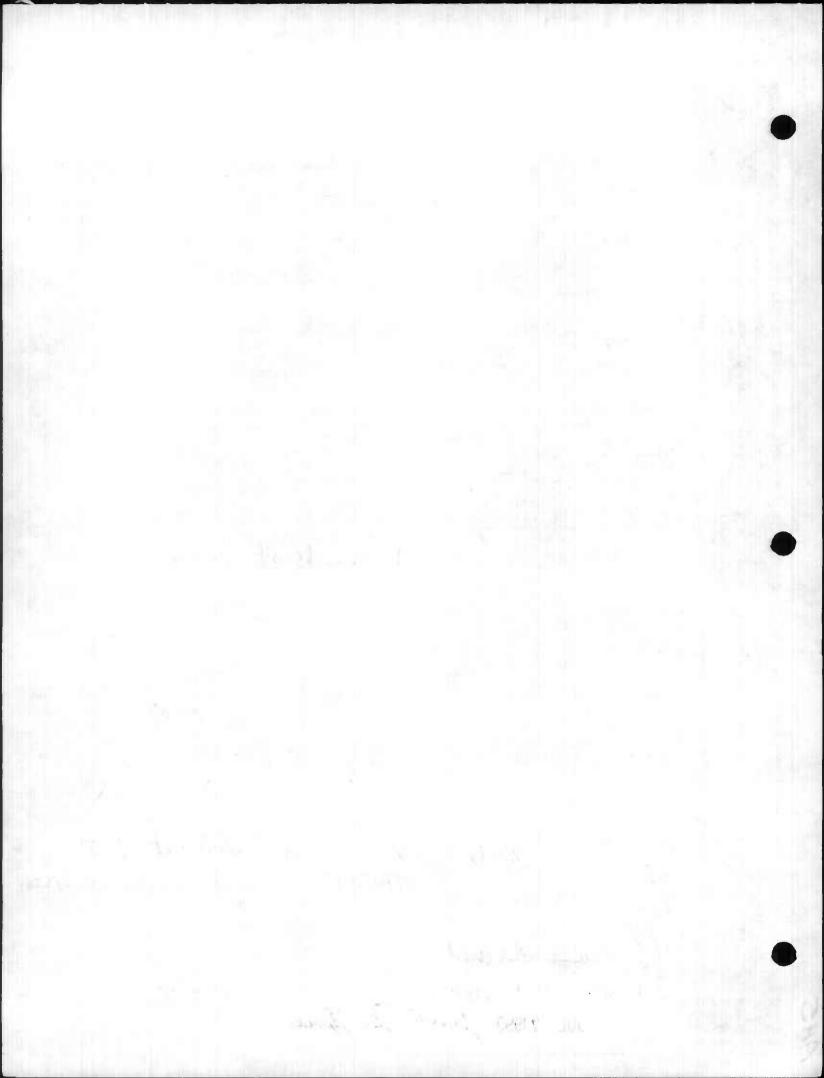


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5-0020 72 hours sher death v 72 hours sher death v 73 hours, or litems 23s fical Examiner must		2. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva Yaar or Datas:	13. Was Decedent of H if Yas, specify Cubs 1 Yas 2 No	lispanic Origin? (Specian, Mexican, Puarto Ri Specify:	ify Yas or No- ican, etc.)	14. Race - Amaric Black, White, Specify: B1	
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Battimore, Ma emit. Pages tand 2 st bepartment of Health and reportants if them 27 is in my injury or other trains note.	19a. Informant's Name/Ralationship (Type Edgar Hopkin  20a. Mathod of Disposition  1 Deurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)  21. Signature of Scheral Service Licenses	S 20b. Place o cemata	. Mailing Addrass (Street 1506 Marble 1506	e Hall Ro	pad Balt Data 20c. 07-06-99	Limore, M. Location - City or To Dunda Maryla	D. 21239 own, Stata lk, MD and 21202
S8760, licate be executed by sician and strangistion and strangistic branch by section 1 and 1 a	23a Part 1. Enter the disease, or complications, or heart failure. List only one immediate Causa (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Dua to (or as a	consequence of):	els of	Head	Q	Approximate Intarval Batween Onset and Death
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Division of or Attending Physical death. Director: After this Jin by the funeral di	27. Manner of Death 1 Natural 5 Pending invastigation 3 Suicide 6 Could not be detarmined	28a. Place of Injury - At homa, fa building, atc. (Specify)	Firma of normal properties of the time of normal properties of the time of time of time of the time of	y at kr? Yas 22 No  28  Ta, data and place, an	City or Toug St.	and Number or Runata)  (S)  (S)  (S)  (S)  (S)  (S)  (S)  (	Al Routa Number,
To the Hospital Within 24 hours To the Funeral completely filled	29b. Signature and titla of certifier	hemo	29c. Licens		29d. Data signed (Month, Day, Year)  JULY 1, 1999		
State	31. Data filed (Month, Day, Year)	plated causa of death (Item 23a)  111  32. Registrar's Signatura	Penn Street	, Baltimore	e, Maryla	and 21201	

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND ITEM #18 PER F.H. G773 6-7-99 J.A. Reg. No. 1. Decedant's Nama (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** 4-05 Am 1999 July /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner North Burnie Arundel GIEN BUY Arunde HOSPITAL 8. Date of Birth (Month, Dey, Year) If Under 1 Yaar Birthplace (State or Foreign Country) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) **Funeral** Days 1□M 200 F -82-4787 MD. 39 Yrs Director 216 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28s-f show 1 X Yas 2 No Director BAlt-more 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Norra 23a 11.5. Funeral IRC 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - Amarican Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Merital Stetus 1 Never Married 2 Married 1 Yes 2 No b Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: / Black à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry MAKE COMPUTER Elementary/Secondary (0-12) College (1-4or 5+) chips Techician 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) - EMMA Be Pages 1 and 2 should be nent of Health and Mental Founes Joseph GAS que 2 19a. informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) important: If Item 27 any injury or other tr MD. 21114 DAlto. Ciecle HAK Rdee 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Buriel 2 Cramation 3 ☐Removal trom Stete 4 ☐ Donation 5 ☐ Other (Specify) Memorial 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility unera Betts Bella CAROL 5+ breeze ine 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory arrest, shock, or heart teilure. List only one ceuse on each line. Approximate Intervel Between Onset end Death Physician /Medical Immediete Cause (Final TATIC CANCER disaese or condition resulting in deeth) Examiner Examiner Sequentielly list conditions, it any, leading to immediate cause. Enter Undarlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): The law requires that the death certificate be exect Box 68760, Physician/Medical Dua to (or as a consequence of): P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributs to the cause of death? 3 Probably 4 ☐ Unknown 1 Yes 2 No signed t þ Records, 24b. Were eutopsy tindings available prior to 24a. Was en eutopsy performed? page 2 should Completed availebla prior to completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 Dolo Division of Vital 25. Wes cese reterred to medical examiner? Be 26. Place of Deeth (Check only one) 1□ Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Appatient 2 ER/Outpatient 3 DOA this 28e. Date of Injury (Month, Dey Year) funeral 27. Menner of Deeth 28h Time of 28d. Describe how injury occurred 28c. Injury et Work? After 5 Pending investigation or Attending 1 Tyes 2 No To the Hospital or Attandii within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and menner es stated.
2 Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. edicai 29a. Certifier completely (Check only

State Registrar

31. Date filed (Month, Dey, Year) 0 7 1999

29b. Signatura and title of certifier

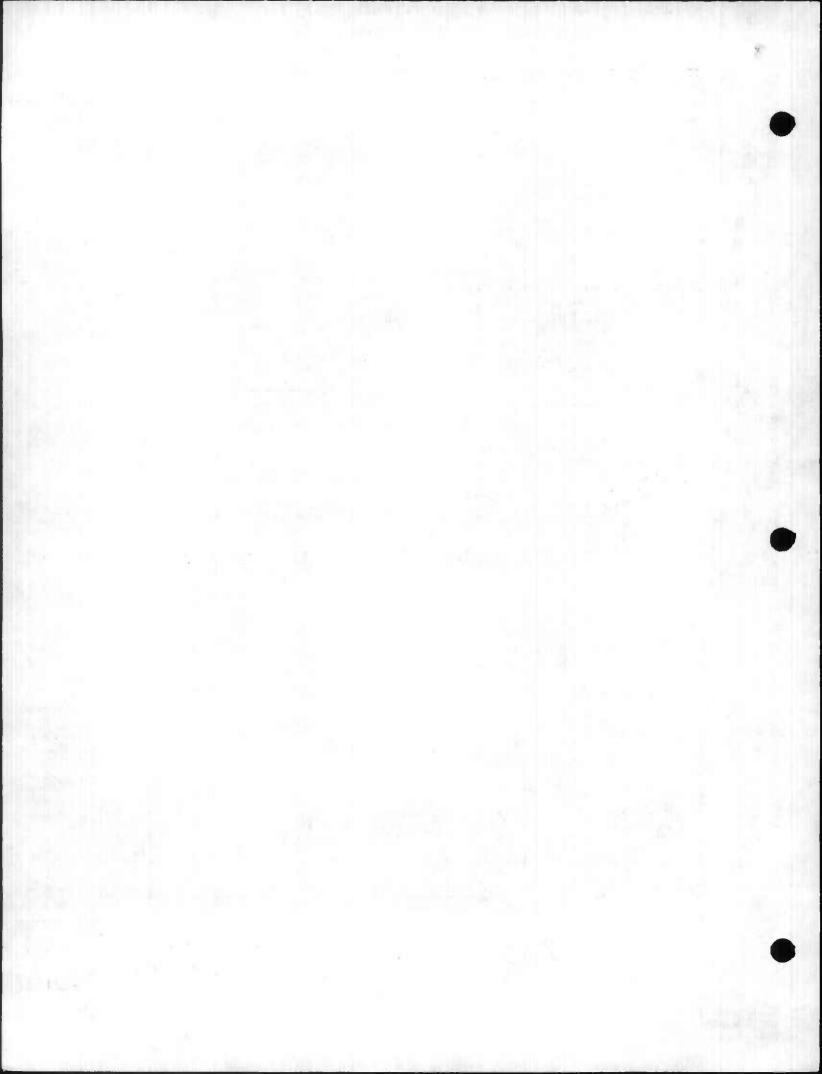
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUDHIR KUMPR AGGARTAL OF THAT PRUNDEL HOSPITAL, 301 HOSPITAL DRIVE, GLENBURNIE, MD 21061 32. Registrer's Signeture.

29c. License number

051664

29d. Date signed (Month, Dey, Year)

1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q AMENDED ITEM #11 PER INFORMANT G775 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** HILL JUNE 20 1999 0340 MELVIN /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL JOHNS HOPKINS If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (le yrs. last birthday) 8. Date of Birth (Month Day, Year) 4-1-4 9. Birthplace (State or Foreign WESTPTY) VIRGINIA **Funeral** Days Hours Director Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location x 28a-f show 10d. Inside City Limits Y No 2 No Director MD BALTIMORE CITY BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? man 23a or U.S.A. 2109 MARYLAND AVE. 21218 Funeral filed within 72 hours after deeth Hygiene. Wher than "natural", or Hema 23 Hema: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien. 11. Marital Status Bleck, White, etc. 1 Yes 2 No
If Yes, Give X
Year or Dates: 1 Never Merried 2 Merried 21215-0020 1□ Yes 2□ No Specify: þ Specify: AFR. AMERICAN 3 Widowed Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. POSTAL SERVICE POSTAL WORKER 17. Fether's Neme (First, Middle, Last) Pages 1 and 2 should be filed nent of Heelth and Mantal Hygi int if fram 27 is marked other Baitimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) Be TOMMIE LEE HILL ALONZO HILL SR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 28 S. ABINGTON AVE. BALTIMORE MD 21229 LAURA M SAUNDERS 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State = 8 Department of Important: If any injury or JULY 12, 1999 BALTO MD ZION CEMETERY 4 Donation 5 Other (Specify) WALKER EUGENE 21 Signeture of Fineral Service Louns 22. Name and Address of Facility ESTEP BROTHERS FUNERAL SERVICE FE 1300 EUTAW PLACE BALTO, MD 2
cations that sourced the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, un MD 21217 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) NEUMONIA 2 DAYS Examiner Due to (or as a consequence of): Examiner AIDS 12 DAYS the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760,  $H \setminus V \oplus$ 10 YEARLS Physician/Medical Due to (or as a consequence of): for use es been signed by the a should be detached Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DIA BETES Division of Vitai Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 No 1 Yes 1 Yes certificate or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: The Inpetient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Neturel 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 24 hours a Hospital

State Registrar **DHMH 16 Ray 6/95** 

completely

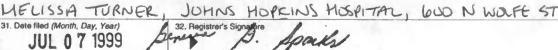
Within 2

31. Dete filed (Month, Day, Year) JUL 07 1999

29a. Certifier

(Check only one)

29b. Signeture end title of certifier



30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

\*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

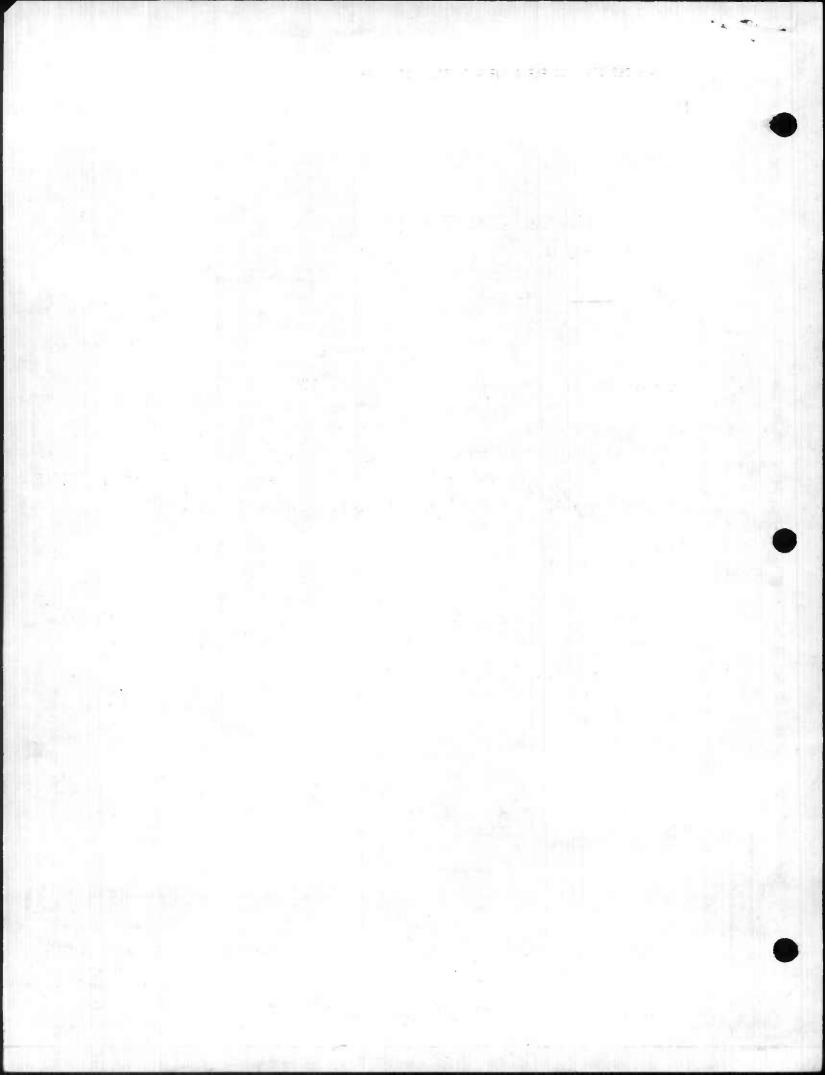
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29d. Date signed (Month, Day, Year)

29

BALTIMORE

MD 21287



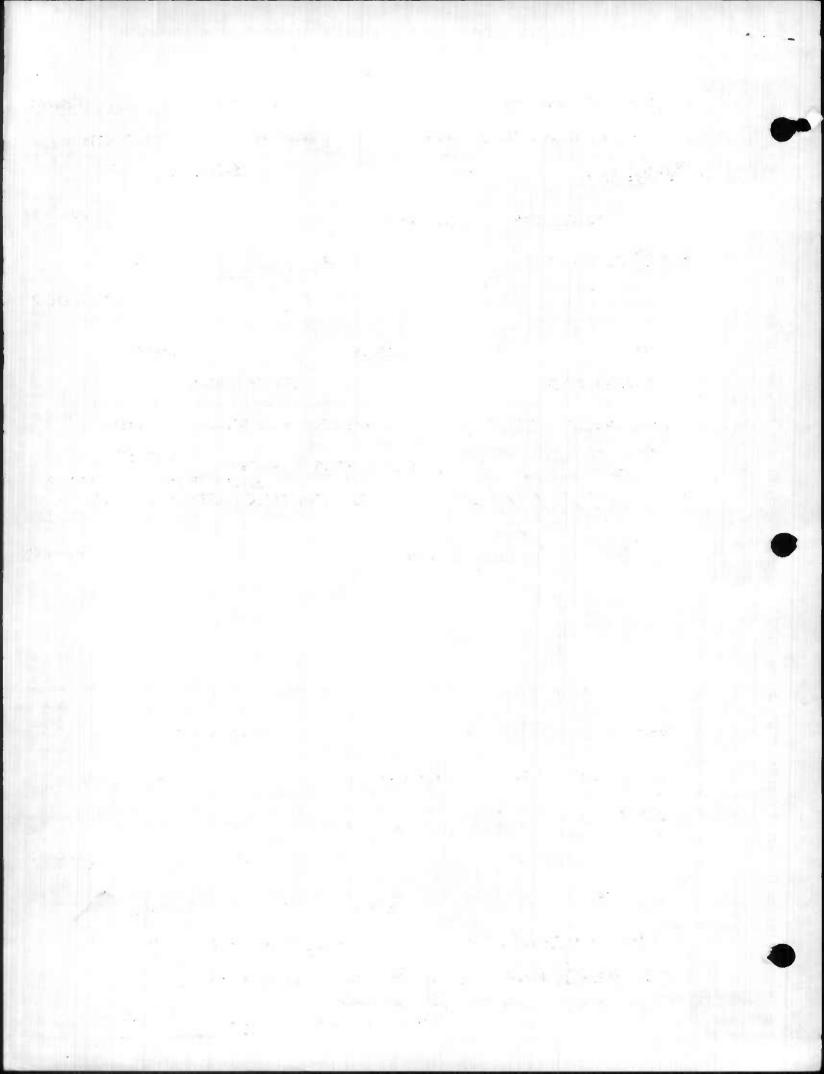
## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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Phys		1. Decedent's Nan	ne (First, Middle, La	ist)		Certifi	outo or			2. Date of De	Reg. No.	3. Time of Death		
/Me	sician edical	Ricky P. Hamilton								July	July 01 11		11:36 AM	
Exa	miner		th not Institution, giv					Baltiv		cation of Death			-1/	
Fune				ex 7. Age (In yrs. last birthday)			Under 1 Year	If Under		8. Date of Bir		TO CIT		
Direct		215-72-		1∭ M 2□ F	40	Yrs. Mo	onths Days	Hours	Min.	8. Date of Bir (Month, De 12-11-1	1958	MD	ce (Stete or Foreign	
pu »		Usual Residence	of Decedent		10a Ciby T	Four or Laboria						100	Leade Challinh	
laryle ahov	5		10a. State 10b. County 10c. City, Town or Location									100	Inside City Limits  VV Yes 2 □ No	
urs after death with the Maryler al, or items 23a or 28a-f show Examiner must be notified at	Director	MD BALTO. CITY BALTIMORE  10e. Street and Number 10f. Zip Code									10g. Citizen of N	What Country		
illed within 72 hours after death with the Maryland Hygiene. Hygiene. The father than "natural", or items 23a or 28a-f ahow mit, the Model at the model of the model.	Ö													
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or h	F		ried 2 Married	1 Yes	No No	1	Yes 2 No	Specify:	i, Fuelto	riidan, etc.)	Specify			
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within 72 ho iene. r than "natur me Medical	Completed		15. Decedent's Education (Specify only highest grade completed)				s Usual Occup of work done NOT use retire	oation during mos d)	t of worki	ing	16b. Kind of B	usiness/Indus	stry	
withir iene.	ошо	Elementary/Sec	ondary (0-12)	Coilege (1	College (1-4or 5+)			KNOWN			UNKNOW	N		
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s 1 and 3 Haaith tam 27			IAMILTON	FATHER			ORTHWO	OD DR	IVE	BALTIMO			Chata	
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Examin	er	disease or condition resulting in death)	on	· lun	CA A TIME									
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State Registrar 31. Dete filed (Month, Pay, Year)

Assertar's Signature Aparls



			Pleas	-		nd / Dep	artme	nt of I			II Coples Iental Hyg	giene	pible.	1276
	Physician	1	1. Decedent's Name (First, Middle, Lust)  Ethel Anna Hunley						Deam		2. Date of Dea Month	Month Day Year		3. Time of Death 8:00 AM
	/Medica Examine	4	a Facility Name (If not institution, Stella Maris H	give street and i	number)			4b. City, Town, or Location of Death Timonium Baltimore						
	Funeral Director		Social Security Number 214-14-8526  Jauat Residence of Decedent	i. Sex 1 □ M 2)() F						4 Hrs. Min.	8. Date of Birth (Month, Day May 6,	7 Year) 1917	9. Birthp Cour Mar	place (State or Foreign http) YLand
w Maryland	the Maryland 28a-f show notified at	1	Oa. State 10b. County Maryland Har	ford	10c. 0	City, Town or L	Bel A	Air					1	0d. fnside City Limits
th with th	5 4 5		Oa. Street and Number 203 Welling to	n Court			10f. Zi	ip Code	21014			10g. Citizen d	f What Cour	ntry?
0020 ours after dea	Examiner must	2	Merital Status     Never Married 2 ☐ Marrie     Widowed 4 ☒ Divorced	d 1 ☐ Yes	scadent Ever in Forces? s 2/2/No Give Dates:	U,S. 13.	13. Was Decedent of Hispanic Origin? (S ff Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ☑ No Specify:			in? (Sp Puerto	ecify Yes or No- Rican, etc.)		ace - Americ lack, White, city: White	etc.
Maryland 21215-0020	Appens. Nor than "natur N, the Medical	displace	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12th Grade	grade complete	d) (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)  Section Manager			of work	ing	16b. Kind of Depar		Store
yland ;	Mental Hyg infraed other rific event,	5	17. Father's Neme (First, Middle, Last) Albert F. Ritter						18. Mother		M. Laf	Maiden Sum		
. 9	m 27 is ma her trauma		19a. Informant's Name/Relationship Mrs. Diane Maye		ghter)	203	well	ling:	ton Ct.		el Route Numbe Bel Air,	MD 2	1014	
Baltimore	rant: If its qury or of		20a. Method of Disposition  1								Date 7/7/99	20c. Location Baltin		Waryland
Bal	Depa Impo any is ansa		Buan a	We	llem		Schin 9705	nunel Beli	ess of Facility R Funer air Rd.	ral <sub>B</sub>	Home, I Baltimor	nc. e, MD	2123	6
1	nysician Medical kaminer	1	23a. Part 1. Enter the disease, or or shock, or heart feilure. List or mmediate Cause (Final disease or condition esulting in death)		AL FAILI				ing, such as c	ardiac (	or respiratory ar	rest,	1	Approximete Interval Between Onset and Death
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of Vital	director	2	5. Was case referred to medicat examiner? 1 ☐ Yes 2 ☒ No	Hospital:	26. Place of Death (Check only one)  Hospital: Other: Other:									HOSPICE
Vision	÷ 5 5 5		7. Manner of Death 1 XNatural 5 Pending 2 Accident 3 Suicide 4 Homicide 6 Could not determine	ion (Mc	e of Injury onth, Day Year) ce of Injury - At Iding, etc. (Spec	28b. Time of fnjury home, farm, st	М	1[	iny at vrk? ] Yes 2 N	lo	28d. Describe h	treet and Nu		al Route Number,
To the Hospital or	within 24 hours a To the Funeral E completely filled Medical Ce		19a. Certifier (Check only one) 1  Certifying 2  Medical Ex	eminer: On the	basis of examin	nowledge, deat nation and/or in	th occurred	d at the ti	ime, date and opinion, death	place,	and due to the cred at the time, c	ause(s) and late and place	manner as s	tated. o the cause(s)
To the	To the comple	,	9b. Signature and title of contifier	and ma	inner stated.		29	_	se number	_		29d. Date sig	ned (Month,	Day, Year)
	5	3	0. Name and address of person wh	o completed ca	use of death (Ite	em 23a) (Type,	Print)			2				

Registrar

State

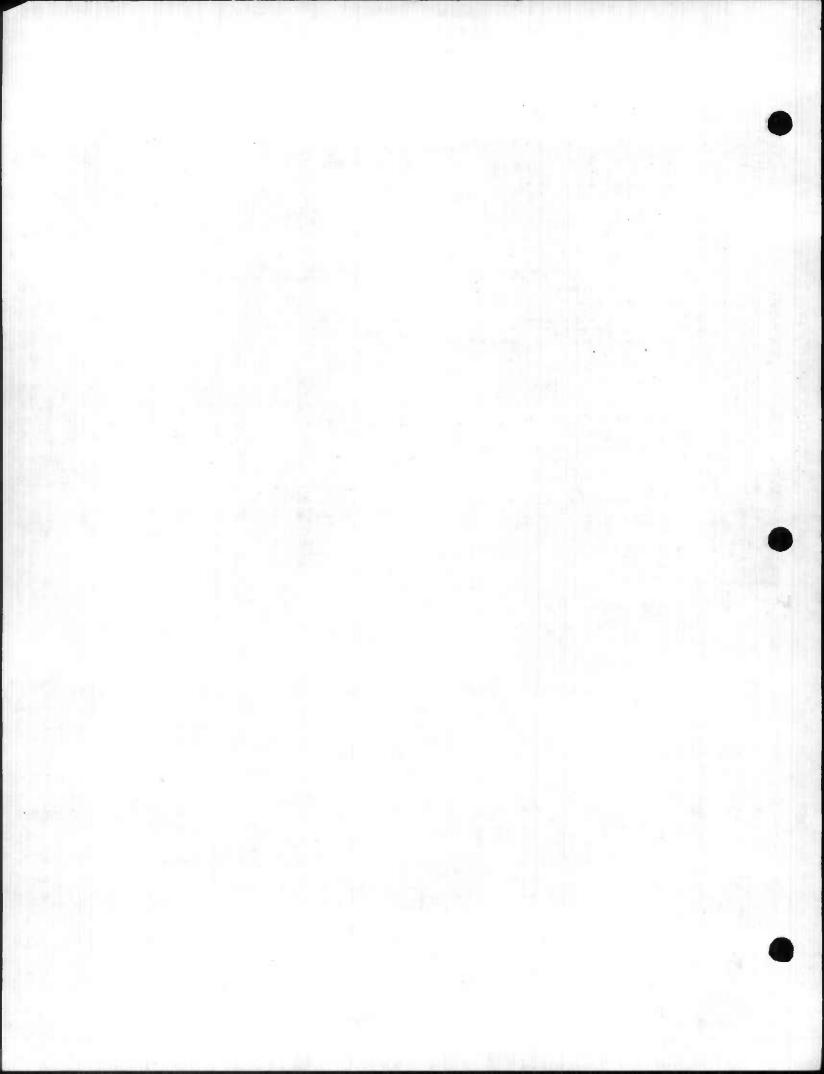
DR. TARIQ MAHMOOD

31. Dete filed (Month, Day, Year)

JUL 0 7 1999

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month 1999 1:10 PM Florence Herbert. 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Baltimore Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 11-23-1922 5. Social Security Number 7. Age (In yrs. last birthday) Months Deys Hours 1 M 2 F 220-12-9984 A 76 Yrs DE Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1X Yas 2 No Md N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 3514 White Chapel Road 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XNo 1 Yes XXNo Specify: **Black** Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry College (1-4or 5+) Baltimore County Board of Education Elementary/Secondary (0-12) Teacher years + 12th grade 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Randolph Milburn Margurerite Congo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Joseph Herbert- Husband 3514 White Chapel Road Baltimore, Md 20b. Placa of Disposition (Name of cemetary, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 D Burial 2 Cramation 3 Removal from State Druid Ridge Cemetery 7-9-99 4 Dogation 5 Dother (Specify) Baltimore, Md Funeral Service Ling 21, Signatur 22. Name and Address of Facility
March F/H West Iter the disease, or complications that caused the cleath. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart feiture. List only one cause on each line. Wabash Avenue Baltimore, Md 21215 Approximate Interval Between Onset and Death 2 DAYS CEREBROVASCULAR ACCIDENT Immediate Cause (Final disease of condition resulting in death) Due to (or as a consequence of): 18 MOS. SEVERE MYELODYSPLASIA Due to (or as a consequence of): Dua to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy

**Physician** /Medical Examiner

> and physician

certificate

After or Attendinate after death.

To the Hospital or A within 24 hours after To the Funeral Direcompletaly filled in b

funeral director,

Be

P L

Certification:

edical

Box 68760.

P.O.

Records,

Division of Vital

**Physician** 

/Medical

**Examiner** 

Funeral

Director

than "natural", or itams 23e or 28e-f show the Medical Examiner must be notified at

altimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 to Department of Health and Mental Hygiene. Important: if Item 27 is merked other than "nati

Director

Funeral

þ

Completed

Be

Examiner burial-tran Sequentially list conditions, if any, leading to immadiate causa. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Physician/Medical the attanding p detach been signed by t should be detact 'Aq Completed

RIGHT UPPER LOBE PNEUMONIA

2 X No 1 Yas 2NNo 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

25.	Was case reterred axaminer?	ed to medical
27.	Manner of Death 1 Natural 2 Accident	5 Pending

28a. Date of Injury (Month, Day Year) invastigation 6 Could not be determined

28h Time of 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify)

12 Inpatient 2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3 Suicide

4 | Homicide

1X Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. ar: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner staled.

29b. Signature and title of certif

29c. License number D-36814

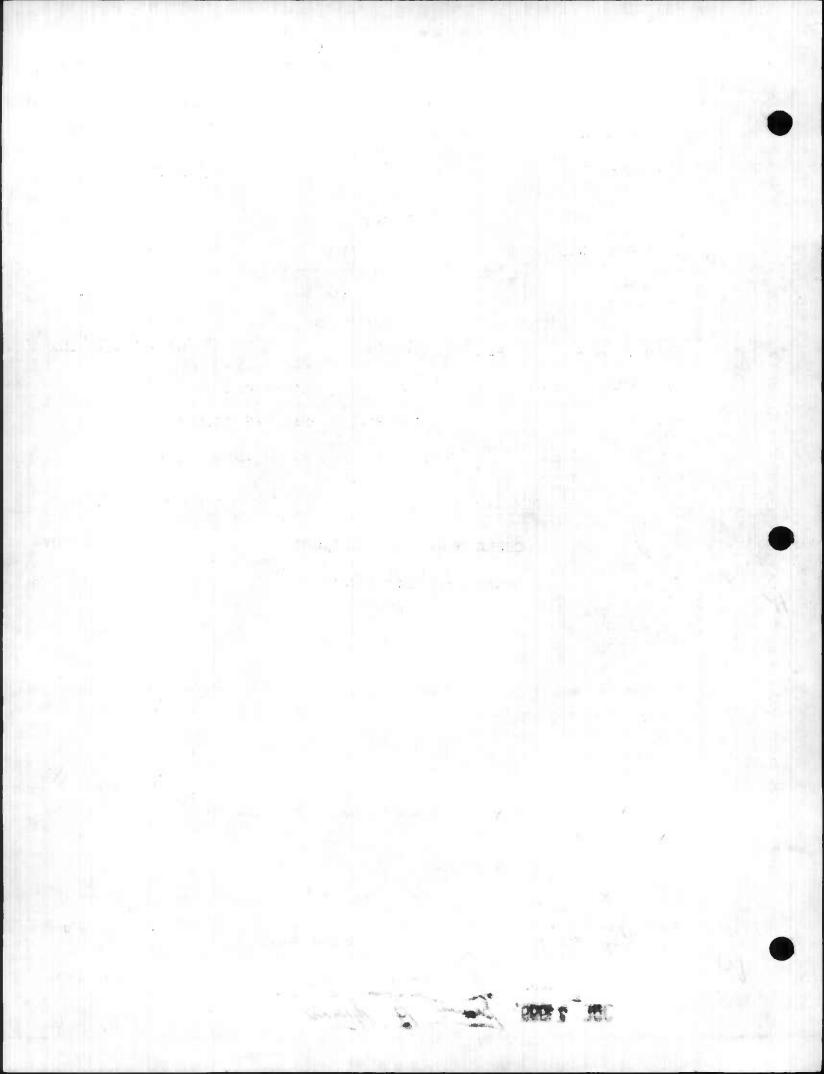
29d. Pate

10

30. Nama and address of person who completed cause of death (liem 23a) (Type, Print) RICHÁRD L. HUŞLIG M.A.

7505 OSLER DRIVE, S-302, TOWSON, MD 21204

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Deta of Deeth 3. Time of Deeth Day 1999 **Physician** Stewart Havward Hanna July 5, 9:33 p.m. /Medical 4a. Fecility Nama (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Towson Baltimore Gilchrist Center 5. Social Sacurity Number If Undar 1 Year If Under 24 Hrs. 8. Deta of Birth (Month, Dey, Year)
Sept. 13,1915

8. Birthplace (Ste County)

Maryland 7. Age (In yrs. lest birthday) Funeral 9. Birthplace (Steta or Foreign Days Hours XXM 2 F 83 213-05-4785 Yrs. Director Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Randallstown Director Baltimore Md. 1 Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21133 U.S.A. 9113 Bengal Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yas 2 □ No If Yes, Give Yaar or Dates: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner 1 Never Married Married b WW II 1 Yes 2 No Specify: by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retirad) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Maryland Cup Manager 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surnema) or and Mental F. Maria Dietz James R. Hanna Pages 1 and 2 should 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 9113 Bengal Rd., Randallstown, Md. 21133 of Hoalth of Nem 27 to Wife Irene Hanna 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other placa) 20c. Location - City or Town, State 1 Buriai 2 ☐ Cremation 3 ☐ Ramoval from State 10 = July 8. 1999 Reisterstown, Md. All Saints Cemetery Injury ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fur 22. Name and Address of Fecility

Eckhardt Funeral Chapel 11605 Raisterstown Rd., Owings Mills, Md. 21117 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heaf failure. List only one cause on each line. Approximate Interval Between Onaet end Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in deeth) DROSTATE CANCER METASTATIC UNENOWN Examiner Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): exe eq Box 68760, Physician/Medicai The law requires that the death certificate the Due to (or as a consequenca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? DISEASE 1 Yee 2 No 3 Probably 4 Unknown MITERN Division of Vital Records, Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? 1 Yea 2 No Attending Physician: Be 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) e Dother (Specify HOSPICE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca P 1 ☐ Yes this 27. Manner of Death in by the funeral 28e. Dete of Injury (Month, Dev Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending deeth. 1 ☐ Yes 2 ☐ No invastigation 2 Accident or Attend after deeth Director: 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, streat, factory, offica building, etc. (Specify) 28f. Location (Straat and Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital To the Hospital within 24 hours a To the Funeral D 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the ceuse(s) end manner as steted. 29e. Certifier Medical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. 29b. Signatura and title of certifiar 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who compl ceuse of deeth (Item 23e) (Type, Print) BACTIMORE MO21204 Co. GOAL 6701 MO 31. Dete filed (Month, Day, Yeer) 32. Registrer's Signeture State 071999 Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** Bernard M. Holland JUNE 1999 10:48AM /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not Institution, give street end number) 4c. County of Deeth **Examiner** TIMORE n/a HOSP SINAI If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) Social Security Number . Age (In yrs. last birthday) **Funeral** 100 M 2 F 48 Yrs. 212-50-2927 **Director** 29, 1950 Usual Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Medical Examinar must be notified at Baltimore Md. n/a 1 Styes 2 □ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21216 USA 3026 Gwynns Falls PKWY FOLLAND, BERNARD Funeral 12. Wes Decedent Ever In U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 Yes 2 Ho ff Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ₩ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiane. Elementery/Secondary (0-12) College (1-4or 5+) Parole Officer State of Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) is marked of Pages 1 and 2 should be nent of Health and Mental Maceo Carroll Charles Holland 19e. Informent's Name/Reletionship (Type, Print) Daughter 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Martina Holland 9048 Continental Place Landover, Md. 20785 Department of Health important: if item 27 20e. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetery or other plece) 20c. Location - City or Town, Stete 1 □ Burlet 2 □ Cremetion 3 □ Removei from Stete 4 □ Donetion 5 □ Other (Specify) ò Alexandria, Va. Saint Mary's Cemetery any injury 22. Name end Address of Fecility Nutter Funeral Homes, Inc. 21. Signature of Funerel Service Licansee 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dylng, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 2501 Gwynns Falls PKWY Baltimore, Md. 21216 Onset and Deeth Physician /Medical Immediate Ceuse (Final METASTATIC COLON CANCER diseese or condition resulting in deeth) Examiner Due to (or es a consequence of) Examiner physician and s the bunal-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): the death certificate be axec Box 68760 Physician/Medical Due to (or as e consequenca of): 88 usa 23h. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yee 2 No 3 Probably 4 Unknown Division of Vital Records. þ 90 24b. Were autopsy findings eveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed page 2 s cartificeta has 1 ☐ Yas 2 ☐ No Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA P 1 Yes a No Aftar this 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Naturet 5 Pending investigation s after deeth. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 ☐ Homicide To the Hospital or within 24 hours of To the Funeral I Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date end pleca, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier 29c. License number 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 2401 BELVEDERE, BALTIMORE, MO 21215 SINGER,

32. Registrer's Signeture

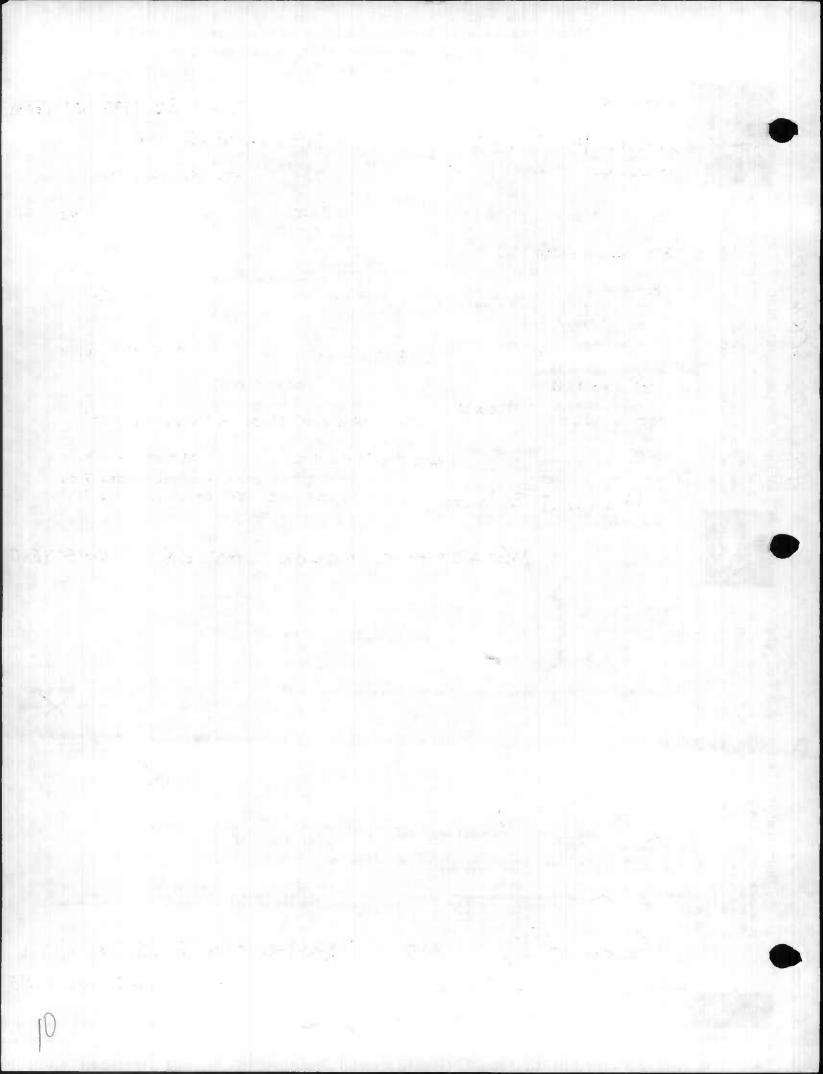
**DHMH 16 Rev 6/95** 

State

Registrar

31. Dete filed (Month, Day, Year)

JUL 0 7 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month Robert Hill, Jr. 26 1999 June 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 499 Maple Ridge Lane Odenton
If Under 24 Hrs. Anne Arundel If Under 1 Year 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 1 M 2 F Deys Hours 75 Yrs 228-20-5538 Usual Residence of Deceder Dec. 16.1923 Virginia 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Anne Arundel Odenton 10a. Citizen of What Country? 10f. Zip Code 499 Maple Ridge Lane 21113 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. TV Yes 2 □ No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: 3\\ Widowed 4 □ Divorced Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SFC US Army 17. Fether's Name (First, Middle, Lest) 18. Mother'a Name (First, Middle, Meiden Surneme) Robert Hill Sr. Mamie Bell 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Vernon Robert Hill (Son) 210 Foxmanor Lane, Glen Burnie, MD 21061 20b. Plece of Disposition (Neme of cemetery, cremetery or other plece) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Maryland Veterans Cemetery 07/01 Crownsville, MD 22. Name and Address of Fecility Hardesty Funeral Home, P.A. 23a. Part1. Enter the disease. Complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest,

Appril 23a. Part1. Enter the disease. Complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest,

Appril 2401 Approximete Interval Between Onset and Deeth e. Acute Cardine/Heart Insufficiency HeArt DISEASE ypertensive

Due to (or es e consequenca of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Last Diabetes Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? BilHteral Renal Transplantation 3 Probably 42 Unknown 1 ☐ Yee 2 ☐ No 24b. Were eutopsy findings avelleble prior to 24e. Wes an autopsy performed? completion of cause of deeth? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 28c. Injury et Work? 28e. Date of Injury (Month, Dev Year) 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Yes 2 No 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

/Medical P.O. Box 68760. Records, Division of Vital

**Examiner** Examiner Physician/Medical Completed certificate has b To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completaly filled in by the funeral director, I Be Medical Certification:

**Physician** 

/Medical

Examiner

**Funeral** 

Director

tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner mant be notified at

pernit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiana. Important: If Nem 27 Is merked other than "r. any Injury or other traumatic event

**Physician** 

the Maryland

Baltimore, Maryland 21215-0020

5. Social Security Number

10a State

MD

10e. Street and Number

10

20a. Method of Disposition

Immediate Cause (Final

Yes 2 No

27. Manner of Death

1 Naturel 2 Accident

3 ☐ Sulcide

29a. Certifier

4 Homicide

disease or condition resulting in death)

Director

þ

Completed

State

29b. Signeture and title of certifier Deputy

29c. License number

006054

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29d. Date signed (Month, Dev. Year)

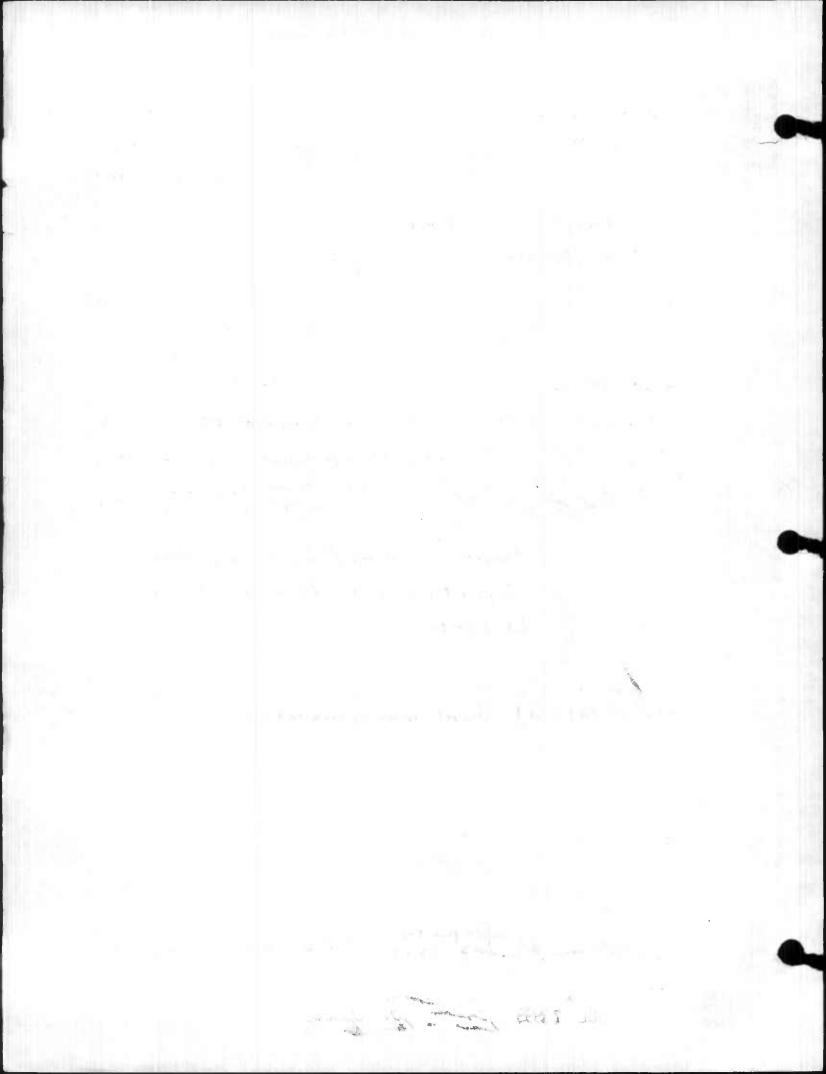
30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

William P. Jones, MD, 6131 ShadySide Rd. Shady Side, MD 20764

1. Date filed (Month, Day, Yeer).

32. Registrac's Signature. 31. Date filed (Month, Day, Yeer)

Registrar **DHMH 16 Rev 6/95** 



### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Madie **Physician** Isaac 16:40 lul /Medical 4b\_City, Town, or Location of De 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner HOSPITCU altimore DING If Under 1 Year If Under 24 Hrs. 8 5. Sociel Security Number 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign 1 M 2 F Months Deys Hours Min. Yrs. 259-40-6593 Usual Residence of Decedent 10c. City, Town or Locetion 10a State 10b. County 10d. Inside City Limits Md Baltimore 112Yes 2□No NA Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Uhler 21215 U.5A 2707 Funerai 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Bigulow Tea College (1-4or 5+) Elementery/Secondery (0-12) Worker Surgrade 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Frank George 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 2707 Baltimore, md 21215 Uhler Anenne Isaac -Hnnotte Daughter 20b. Plece of Disposition (Name of cametery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Buriel 2 Cremation 3 Removal from Stete 4 Donetion 5 Other (Specify) Randallstown, Memorial 22. Name end Address of Fecility 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Balto, ruel 2/215 Immediate Cause (Finel disease or condition resulting in deeth) Examine prebrovascu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Strue Physician/Medical Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other eigniffcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 4 Unknown 1 Yes 2 No 3 Probably þ 24b. Were eutopsy findings eveileble prior to 24e. Wes an autopsy performed? Completed completion of cause of deeth? 1 ☐ Yes 2 No 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 Appatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 TYes 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 281. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Sulcide Place of Injury - At home, Ierm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner es steted. 29e. Certifier Medical

physician and the burial-transit certificate be executed Division of Vital Records, P.O. Box 68760, Se esn signed t page 2 certificate or Attending Physician: director. this funerei Aftar 24 hours after death.

Funeral Director: A Hospital

**Funeral** 

**Director** 

r 28a-f show

Item 27 is marked other than "natural", or Items 23a or other traumatic svant, the Medical Examiner must be a

nemit. Pages 1 and 2 should be 1 bepartment of Health and Mental Himportant: If Item 27 is marked of

ò

Injury

**Physician** /Medical

Examiner

the Maryland

within 2

State Registrar

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Internal

29c. License number

29d. Dete signed (Month, Dey, Year)

29b. Signeture end title of certilier

Medicine Resident

AS2402321-9493

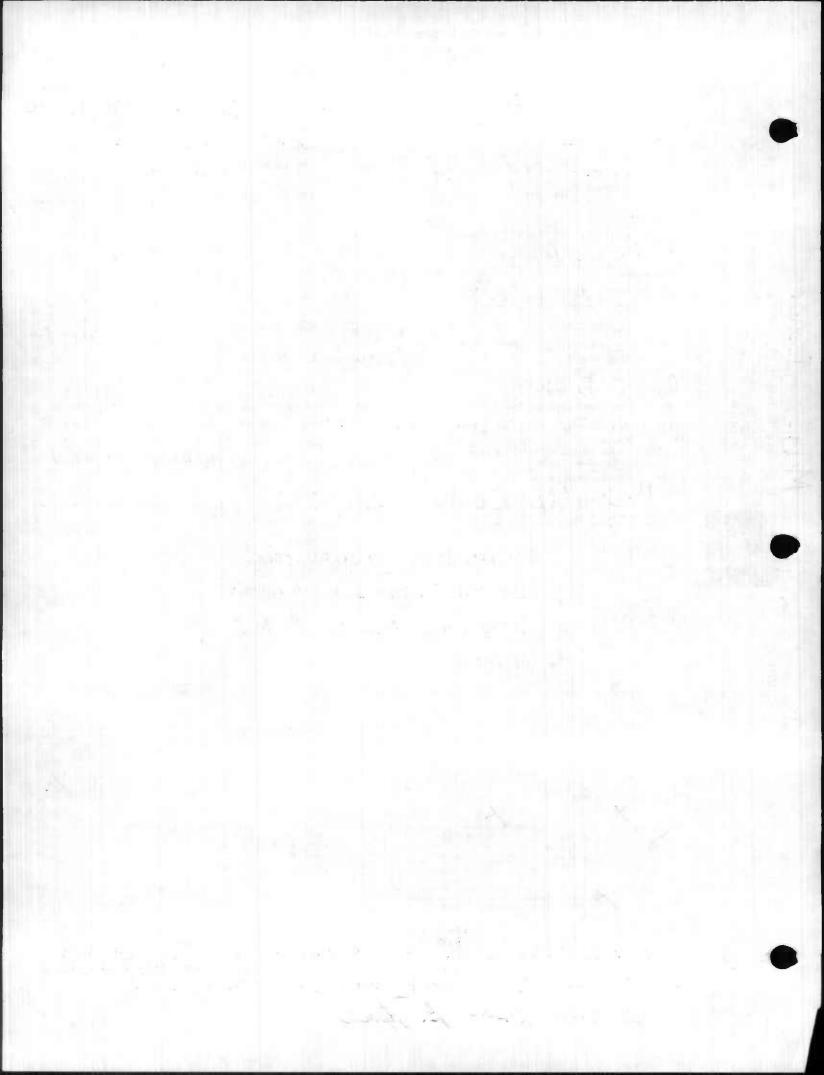
30. Name end eddress of person who completed ceuse of death (Item 23e) (Type, Print) Sinai MOPHO. Hospital, Erondu.

Baitimore, Merryland Belvedere Avenue

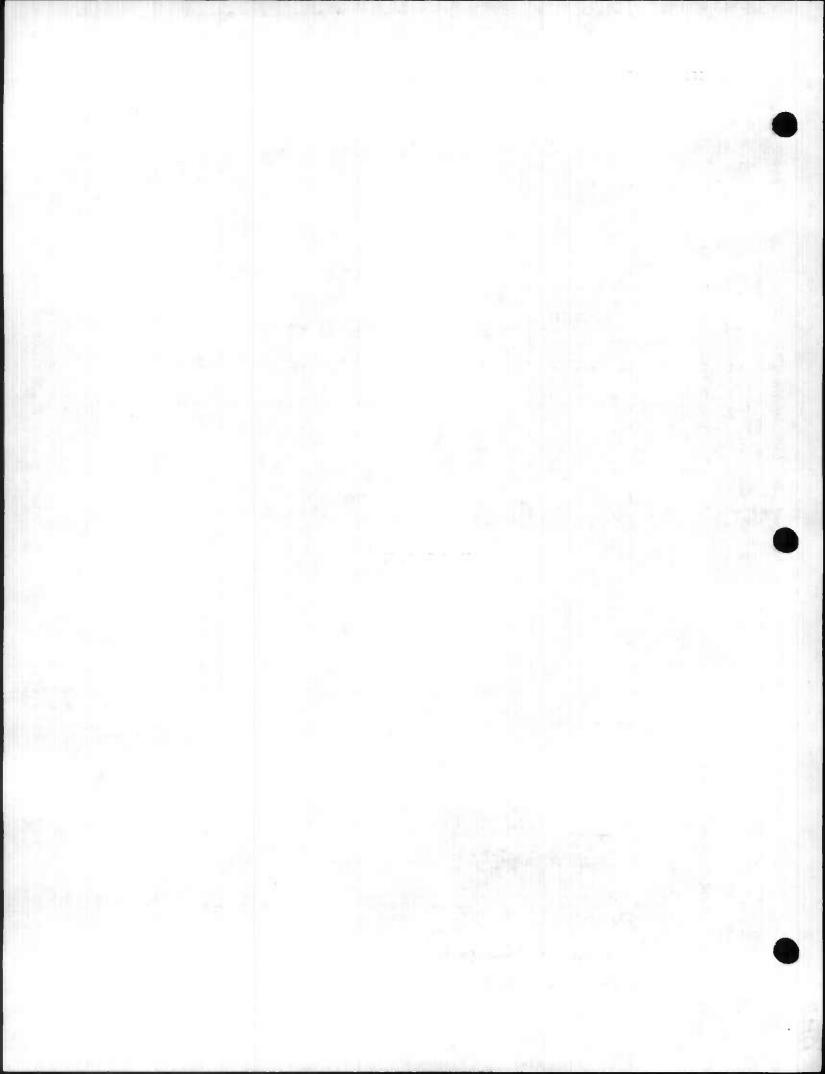
Ugochi 31. Dete filed (Month, Dey, Year) 7 1999

(Check only one)

2401 West 32. Registrer's Signeture



DEBRA JOHNSON J	TFM#23 PART 1 27 28a - f F	State of Ma		Gertific				Reg. No.	3, Time of De	aath	
Physician /Medical	Deborah Ann	Johnson					Month JUNE	Day 30,199	Year 99 11:48F		
Examiner	4a Facility Name (If not institution, give MERCY MEDICAL CENT				**	4b. City, Town, or I					
Funeral Director	5. Social Security Number 6. Se		(In yrs. last b	irthday) If Ur Mont	der 1 Year hs Days		8 Date of Birt	NA Birth Day, Year) 03-65  NA 9. Birthplace (State of Country) MD			
9	Usual Residence of Decedent										
r 28a-f show Indiffied at frector	10a. State 10b. County 10c. City, Town or Location								10d. Inside City I		
or 28a-f s be notified Director	MD NA		Balt	imore	Zip Code	,		10g. Citizen of W			
5 0H D	321 East LaFay	ette Ave	nue	101.	2120	12					
ther death verification in the state of the		12. Was Decedent Ev		13. Was De		Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No	USA 14. Race	- American Indian,		
by Er.	1 Never Married 2X Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:			specify Cub s 2 No		o Rican, etc.)		Black		
alcal dical	15. Decedent's Edu (Specify only highest grad	cation	168	Decedent's U	sual Occu	pation during most of world)	kina	16b. Kind of Bu	siness/Industry		
ygiene. Net then "neturn rt, the Medical. Completed	Elementary/Secondary (0-12) 12th Grade	College (1-4or 5+	)			nd)	9	vario	s trades		
	17. Father's Name (First, Middla, Last)	NA		Labor	.er	18. Mother's Nan	na /First Middle				
metic ever	James Heat	h, Jr.				Antoin	nettei	a Cr	rawford		
m 27 to n her traur	19a. Informant's Name/Ralationship (Ty Duane Johnso		3	21 E.	Lafa		Rural Route Number, City or Town, Stata, Zip Code) Avenue Baltimore, MD. 2				
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hysician	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused to ne cause on each line	he death. Do	not enter the r	node of dy	ing, such as cardiac	or respiratory ar	rest,	Approximate Interval Betwee Onset and Dec	ien ath	
/Medical examiner	immediate Cause (Finat disease or condition resulting in death)			XICATION	of):				0	9.9	
cian and buria-Hransit al Examiner	Dua to (or as e consequence of):										
burial-fransit	Sequentially list conditions,	ally list conditions,  Due to (or as a consequence of):									
E Scie	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disaasa or Injury										
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by the	Part II. Other significant conditions con	tributing to death but	not resulting	ng in the underlying cause given in Part I. 23I				b. Did tobacco use contribute to the cause of death  1 Yes 2 No 3 Probably 4 Unknow			
sate has been signed, page 2 should be de								an autopsy rmed?	available prior to	completion of cause	
certificate has breactor, page 2 s							K	res 2□No	Yes 2□ No	0	
	25. Was case raterred to medical examiner?	lospitat:			Ot	26. Place of Dea					
£ 5	1 XYes 2 No  27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury (Month, Day)		Time of	28c. Inju	4 LI Nursing H		dence 6 Other			
r death. ector: After by the fune ification	1 Natural STPANDING 2 Accident investigation		UNK	NOWN M		ork? ]Yes 2√√∑No		UNKNOWN			
육동 도	3 Suicide 4 Homicide  8 Could not be Adetermined  8 Could not be building, etc. (Specify)  UNKNOWN					et, factory, offica 28f. Location City or To			(Street and Number or Rural Route Number, own, State) JMKNOWN		
within 24 hours of To the Funeral I completely filled	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	sician: To the best of ner: On the basis of e and manner state	xamination as	e, death occur nd/or invastiga	red at the ti	ime, date and placa opinion, death occu	, and due to tha rred at the tima,	causa(s) and ma date and placa, a	nner as stated. and dua to the cause(s)		
within To the compl	29b. Signature and title of certifier	1 .	^		29c. Licen	se number		29d. Date signed	(Month, Day, Year)		
> - 0	· Can	toker	w		0.0	C.M.E.		JULY 1,1	1999		
	- 10 / 1	empleted cause of dea	ath (Item 23a)		Penr	Street,	Baltimo	re, Mary	yland 21201		
State Registrar	31. Date filed (Month, Day, Year)		Signature	. So	aks	/					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 2101 pm Arlena Louise Johnson Jul 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street end number) 4c. County of Deeth Prince Laurel Hospita Greate Laure 7. Age (in yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Months Days 1 M 2 JF 226-48-5154 59 JAN. 9. 1940 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits MD Howard 1 ☐ Yes 2 ☐ No Elkridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6514 Vert Drive 21075 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 □ Never Merried 2 □ Married 1 ☐ Yes 2 X No Specify: white Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Domestic 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Earl Craiger Bonnie P. Minnix 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Diana L. Smith - daughter 7105 Ohio Avenue, Hanover, Md. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 7/09/99 Dete 20c. Location - City or Town, State 1 X Burial 2 Cremetion 3 Removel from State Meadowridge Memorial Pk. Elkridge, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21075 Approximate Interval Between Onset and Death Immediate Cause (Final ratic Cardiovascular Disense diseese or condition resulting in deeth) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or es e consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yss 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner es stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29c. License number

29d. Dete signed (Month, Dey, Year)

Records, P.O. Box 68760

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

**Funeral** 

Director

the Mervie

Item 27 is marked other than "natural", or items 23s or 28s-f show other traumetic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filled within 72 hours after death with Department of Health and Mentel Hygiene. Important: if item 27 is marked other than "--- any injury or other traumest- any solute.

**Physician** /Medical

Examiner

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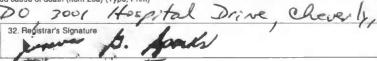
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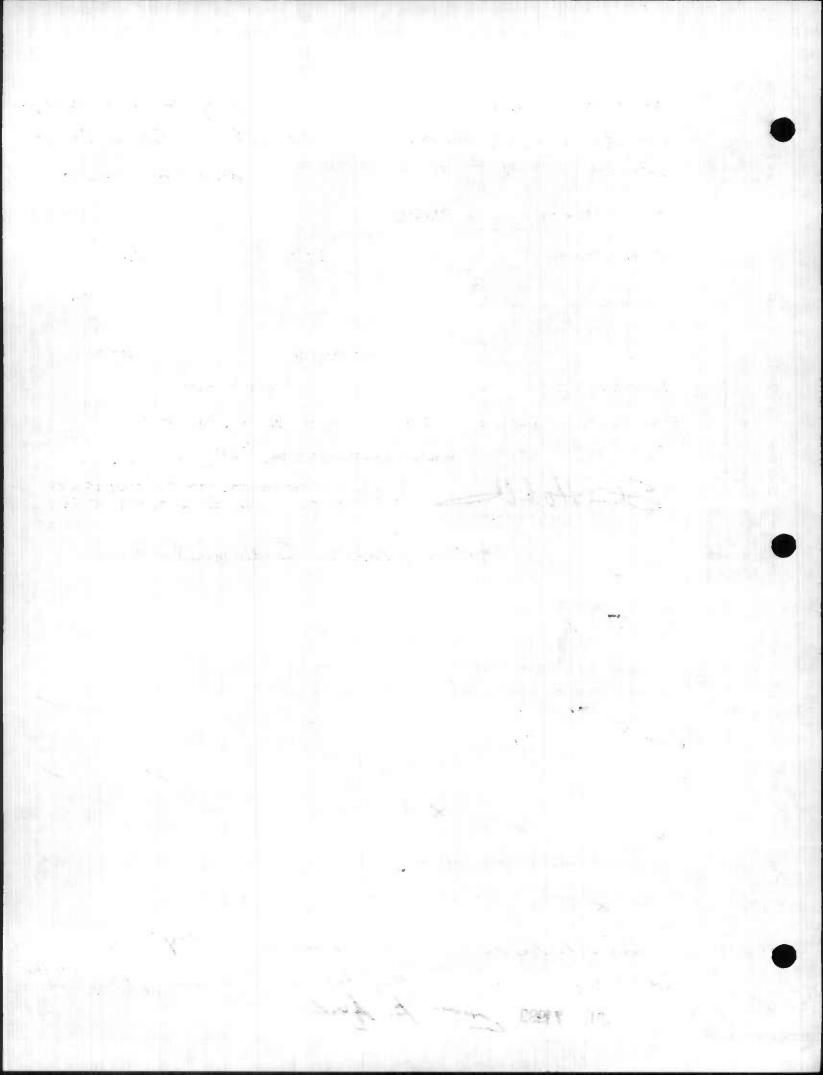
29b. Signeture end title of certifier

Division of Vital

State Registrar



o completed cause of death (Item 23a) (Type, Print)



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM#19a PER INFMNT. G773 7-14-99 J.A Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Day Month **Physician** JOHNSON PERNILL 45 Am 1999 TULY /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** HOSPITAL BALTIMORE SECOURS BON If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) **Funeral** Deys Months Hours 1□ M 2₩F 214 18 6333 89 Dec. 2,1919 Director Maryland Usuel Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or items 23s or 28s-f sho The Medical Examiner must be notified at 1 Yes 2 No Maryland n/a Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1306 W. Lexington St., 1st Floor 21201 United States Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11 Maritel Status 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black p 3℃Widowed 4 □ Divorced Yeer or Detes: Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Domestic permit. Peges 1 end 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked other any injury or other traument other traumatic event, 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Alonso Acree Mary Pritchett 2 19e. Informent's Name/Reletionship (Type, Print) EAISON Stanley Johnson / Son 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 550 St. Mary St., Baltimore, MD 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 200 remetion 3 Removel from State Green Mount Crematory 7/7/99 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD 22. Name end Address of Fecility CAFA Stephen D. Lohrmann P.A. Hollman 8717 Green Pastures Dr., Baltimore, MD 21286 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel PNEUMONIA disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Physician/Medical Examiner DEHYDRATION Due to (or es e consequence of): and buriel-trar Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated execut. physician Box 68760 certificate be thet initieted events resulting In deeth) Lest the Due to (or es e consequence of): USB 85 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown CANCER BREAST Records, þ 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy peeu page 2 certificate has 1 Yes 2 No 1 Yes 2 No Division of Vital Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) examiner? Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 1 ☑ Netural 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury et Work? After 5 Pending Investigation al or Attending setter death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide in by 1 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 24 hours 1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the bests of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end piece, and due to the cause(s) end menner steted. 29e. Certifier Medical To the Hosp within 24 ho To the Fune completely f (Check only one) 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signeture and title of certifier

State Registrar **DHMH 16 Ray 6/95** 

31. Date tiled (Month, Dey, Yeer)

THOMAS

nicun 32. Registrer's Signature

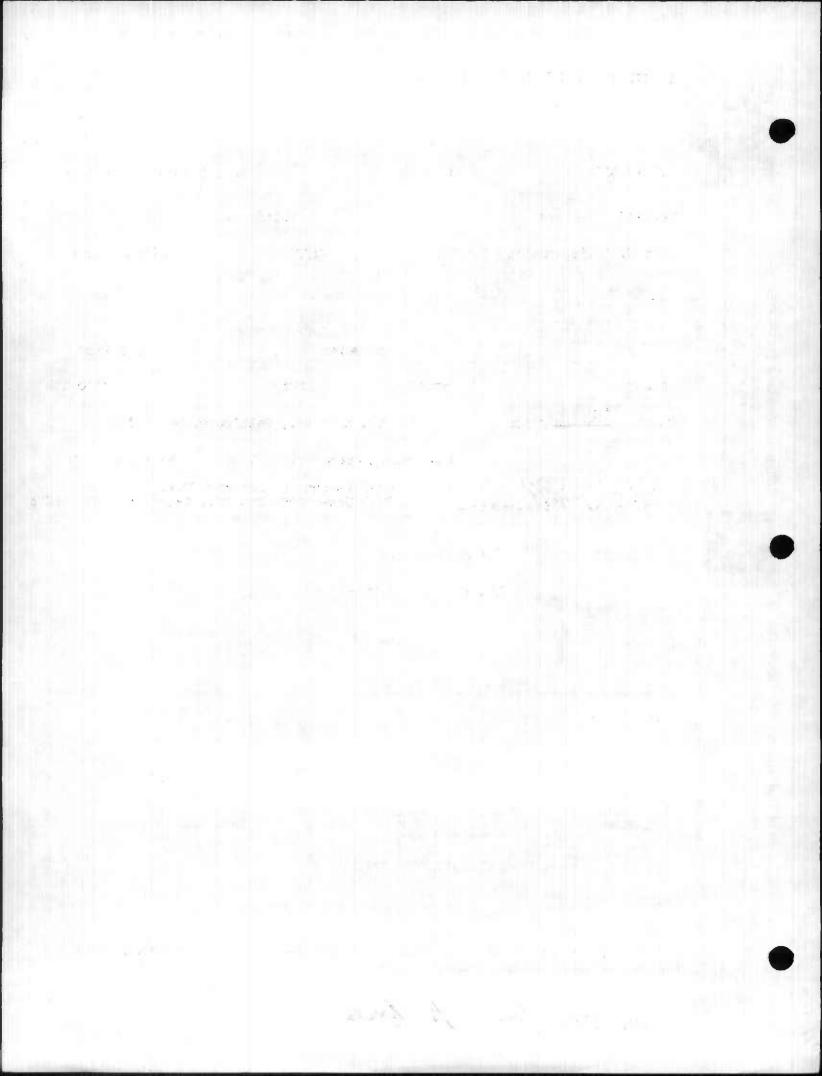
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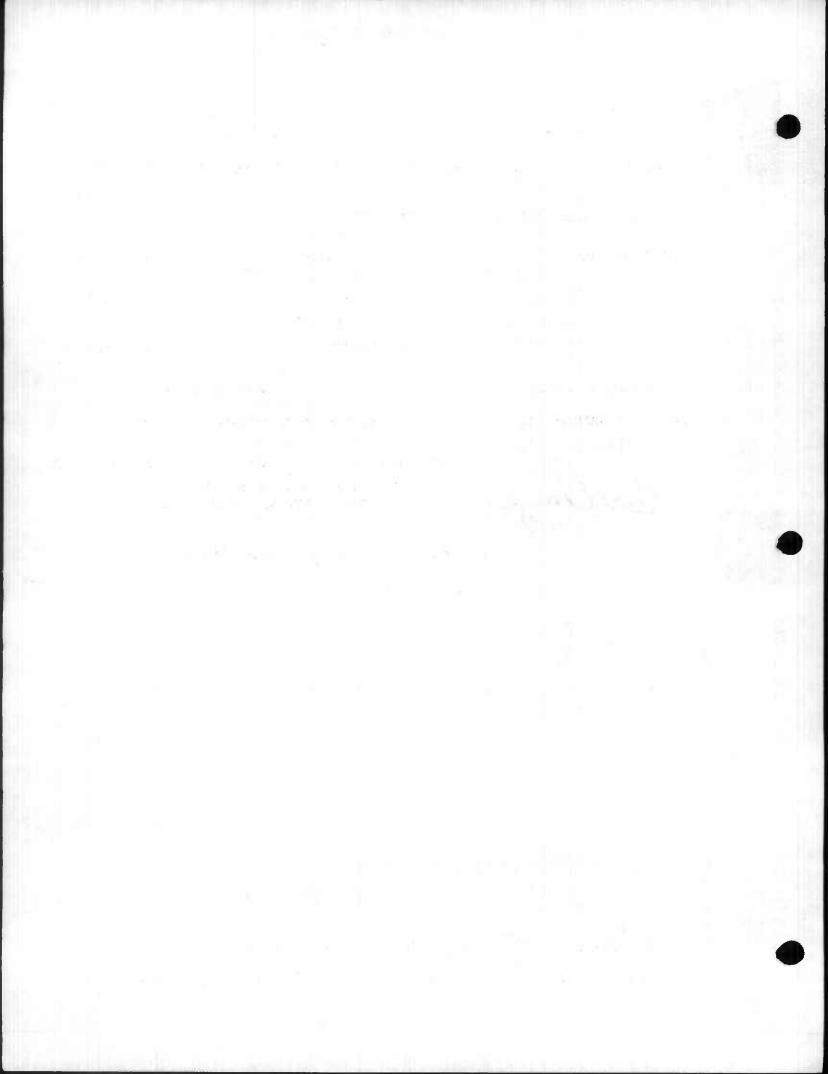
melle

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print)



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-		Decedent's Name (First, Middle		OI Waryia	_	rtment of				eg. No.	) 2	12	83
Physic /Med	ical	A i Ce  4e. Fecility Neme (If not institution	,	Jan	nes		4b. City, Tov		Month July	Dey 5 /4 4c. County	Yeer 999		of Death 40 PM
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Funeral Director		5. Social Security Number 220–26–0122	6. Sex 1 ☐ M <b>②</b> ○XF	7. Age (In yrs 69	: last birthdey) . Yrs.	If Under 1 Year Months Deys			Dete of Birth (Month, Day RCH I	5, 1930	9. Birthp MAR	lece (State IV) YLAND	e or Foreign
and		Usuel Residence of Decedent  10a. Stete 10b. County		10c. C	ity, Town or Loc	eation				-	1	Od. Inside	City Limits
Manylan H show	tor	MARYLAND ANI	NE ARUNDE			N BURNI	Ξ						s 2 No
or 284	Director	10e. Street end Number				10f. Zip Code			1	0g. Citizen of V	Vhet Cour	itry?	
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permit. Peges Department of I Important: If Ita any injury or of		21. Signature Funeral Service		M	22. KI	EMATORY Name end Addr RKLEY-RU	JDDICK	FUNER	AL HO	ME P.A.		ILLE,	MD
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		30. Name and address of person of MING	who completed cau	ise of deeth (Ite	m 23e) (Type, F	cian . rther	n Par	Kuln	u B	l+m=	ne	212	14
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## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth H. Courtenay Jenifer, Jr. ULY. 10 4b. City, Town, or Location of Death 4a Fecility Name (If not Institution, give street end number) 4c. County of Deeth Levindale Hebrew Geriatric Center and Hospital Baltimore NA If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) If Under 1 Year Birthplace (State or Foreign Country) 1 M 2□ F Deys Months Hours 212-28-0115 May 20, 1913 Towson, Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Baltimore Co. Maryland Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 16 Pine Bark Court 21030 United States of America 12. Wes Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No W.W.II If Yes, Give Year or Detes: Reca - American Indian, Black, White, etc. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 1 □ Never Married 2 □ Married 1 Yes 2 XNo Specify: White 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuei Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) Coilege (1-4or 5+) 12 n/a Insurance Agent Insurance 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) H. Courtenay Jenifer, Sr. Ilma Massenberg 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Mr. Clinton P. Pitts(Co-Trustee) 1055 West Joppa Road Apt. 522 Towson, Maryland 21204 20b. Pleca of Disposition (Neme of cemetery, crematory or other pleca) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 X Buriai 2 Cremetion 3 Removel from State Druid Ridge Cemetery 7/09/1999 Baltimore, Maryland 4 □ Donetion 5 □ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Foneral Servica Licensele Jeffrey L. Gair 1050 York Rd. Towson, Md. 21204 23a. Part 1. Enter the disease or complication and caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one or use on each line. Approximate Intervei Between Onset and Deeth immediate Cause (Final disease or condition resulting in death) Cardio myspelly Amal In 11 ahou Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Lest Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Whiknown 24b. Were eutopsy tindings aveileble prior to 24a. Was en eutopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□ No 11 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Menuer of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Naturai 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and pieca, end due to the ceuse(s) and menner as stated. 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, and due to the cause(s) and menner steted. (Check only one)

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**Physician** 

/Medical

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**Funeral** 

Director

7 is marked other than "natural", or items 23s or treumstic event, the Medical Examiner must be a

2 should be filed within 72 hours after n and Mental Hygiene.

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**Physician** 

/Medical Examiner

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29b. Signeture end title of certifier

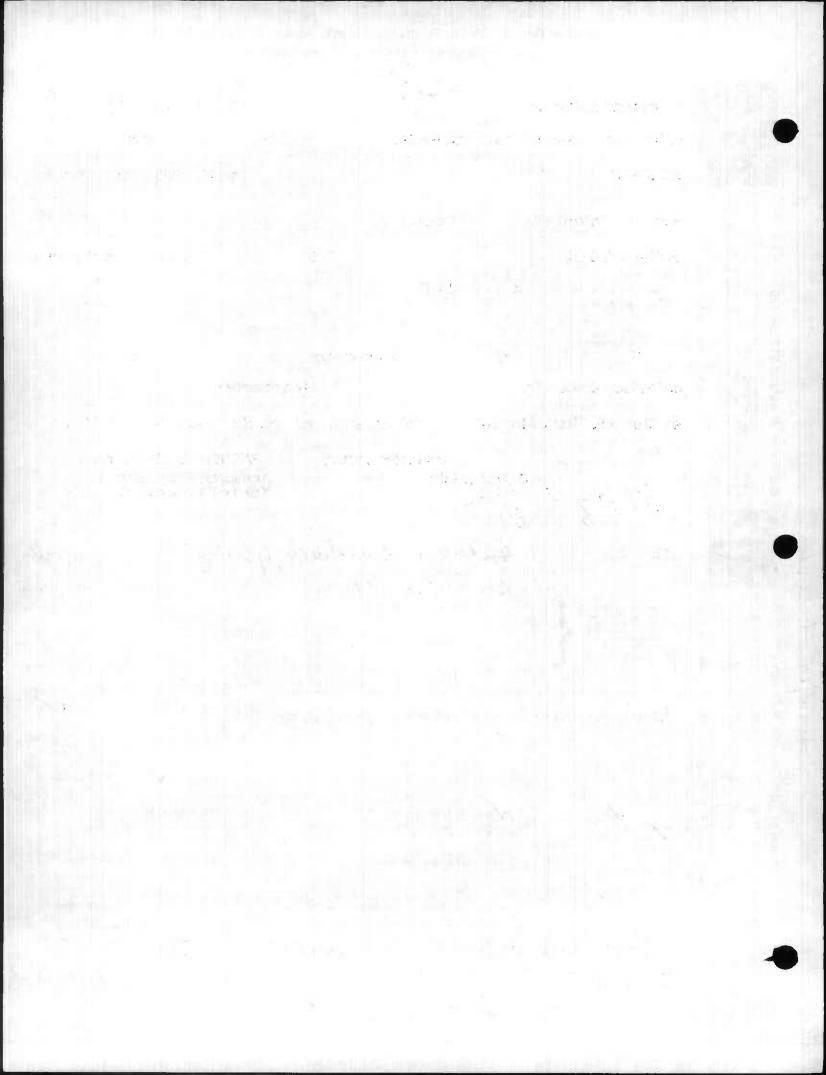
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29c. License number

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Suni R. Rejane 3434 & Belwedere Cure, Haltinore, Lealyland

32. Registrer's Signeture



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** MARY **JOAN JACKSON** 03,1999 July 04:40pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** Greater Baltimore Medical Center Towson Baltimore If Under 24 Hrs. Hours Min. Jan. 31, 1930 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Steta or Foreign Country) **Funeral** 10 M ATT Months Days 215-24-2782 69 Director Maryland Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Insida City Limits 10b. County MD Baltimore Lutherville 1 Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 123 Dublin Drive 21093 United States Funerai 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes XXNo If Yes, Giva Yaar or Dates: ` 14. Race - American Indian, Black, White, etc. 1 Never Married XX Merried 1 ☐ Yes 2 No Specify: Specifiwhite p 3 Widowad 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) 5 + Registered Nurse Nursing 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Sullivan Paul Lewis Jeanette Elizabeth Reynolds 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Mr. Charles Leo Jackson/husband 123 Dublin Drive Lutherville, MD 21093 20b. Place of Disposition (Neme of cematery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Dulaney Valley Mem. Grd.07/08/99 Timonium, Maryland 22. Name and Addrass of Facility Ruck Towson Funeral Home, Inc. Stephen D. 1050 York Road Towson, Maryland 21204 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onsat and Death Immediate Causa (Final disease or condition resulting in death) 90 Due to (or es e consequence of): Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an autopsy pertormed? Completed 200 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Dhpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2000 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and plece, and due to the cause(s) and mannar as stated. edicai (Check only 2 Madical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and titia of certifier

State Registrar

0 7 1999

31. Dete filed (Month, Dey, Year)

30. Neme end eddress of person who completed cause of

32. Registrar's Signature

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**DHMH 16 Rev 6/95** 

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Baltimore, Maryland 21215-0020

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**Physician** 

/Medical

**Examiner** 

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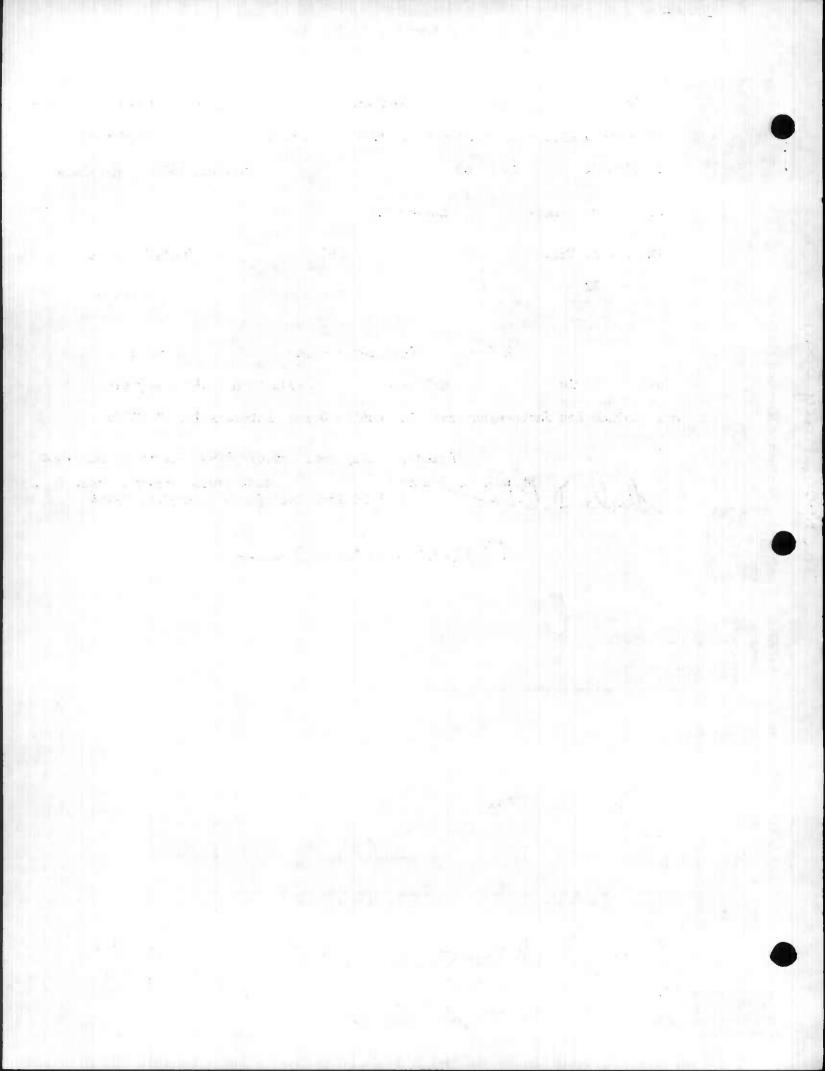
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The law requires that the death certificeta be axecuted

Division of Vital Records, P.O. Box 68760.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Time of Deeth Charles Warren JULY 6 1999 Keenan 5:47 PM 4a Facility Nama (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Deeth Joseph Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth Months Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Months 12 M 2□ F Yrs. 217-03-8975 78 Oct 17, 1920 MD Usual Residence of Decedent 10a, Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yas 2 XNo MD Baltimore Dundalk

with death altimore, Maryland 21215-0020

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

the Maryland

flam 27 le marked other than "natural", or flama 23a or 28a-f ahor other traumatic event, the Maidical Examples must be northed at permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if flem 27 le marked other than "natural", or iten any injury or other traumatic event, the Health France Physician

/Medical

Examiner

physician and s the burial-transit certificate be use as for use as the hed detach been signed by t should be detact has

P.O. Box 68760 Division of Vital Records. page 2 funeral director, this After death. or Attend after death Director: 24 hours within 2 To the

Director 10e. Street and Number 10f. Zip Code 10g. Cifizen of Whet Country? 7610 Dunmanway 21222 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indian, 11. Marital Status Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify. b 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) MVA Investigator State Government 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Howard Keenan Hilda R. Collier 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beulah Keenan /wife 7610 Dunmanway Dundalk, MD 21222 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1X Burlal 2 ☐ Cremetion 3 ☐ Removal from State July 10 4 ☐ Donetion 5 ☐ Other (Specify) Holy Redeemer Cem. Baltimore, MD 22. Name and Address of Fecility
Connelly Funeral Home of Dundalk 21. Signeture of Funeral Service Licensee 7110 Sollers Point Rd 23a. Pert1. Enter the disease, or complications that caused the deels. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Daath ATHEROSCLOROTIC CARDIOVASCULAR DISEASE Immediate Cause (Final disease or condition resulting in death) 18 YEARS Due to (or es e consequence of):
CONGESTIVE HEART FAILURE Examiner 1 YEAR Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of) HEMORRHAGE 1 DAY Physician/Medical Due to (or es a consequence of) RE-DO BYPASS AND MITRAL VALVE SURGERY DAY 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Was an eutopsy 25 NO 1 Yes 25. Was case refarred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 2 ER/Outpatient 3 DOA

State Registrar

Certification:

Medical

31. Date filed (Month, Dey, Year)

27. Menner of Deeth

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

29b. Signeture end title

Neturel

JUL 0.7 1999

5 Pending Investigation

6 ☐ Could not be

32. Registrar's Signature

M. D. ,

28e. Dete of Injury (Month, Dey Year)

cause of death (florm 23a) (Type, Print)
7505 OSLER DRIVE , TOWSON, MARYLAND 21240 outs

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner attribut.

23045

29c. License number

1 Yes 2 No

28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, State)

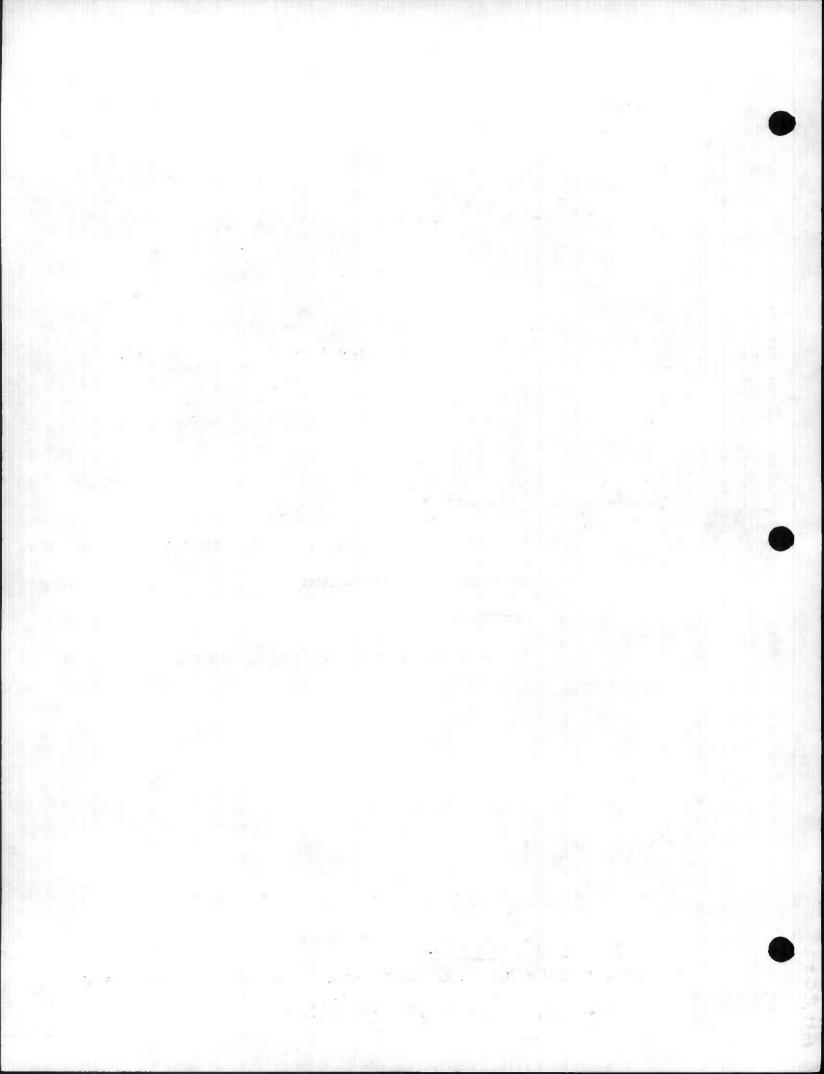
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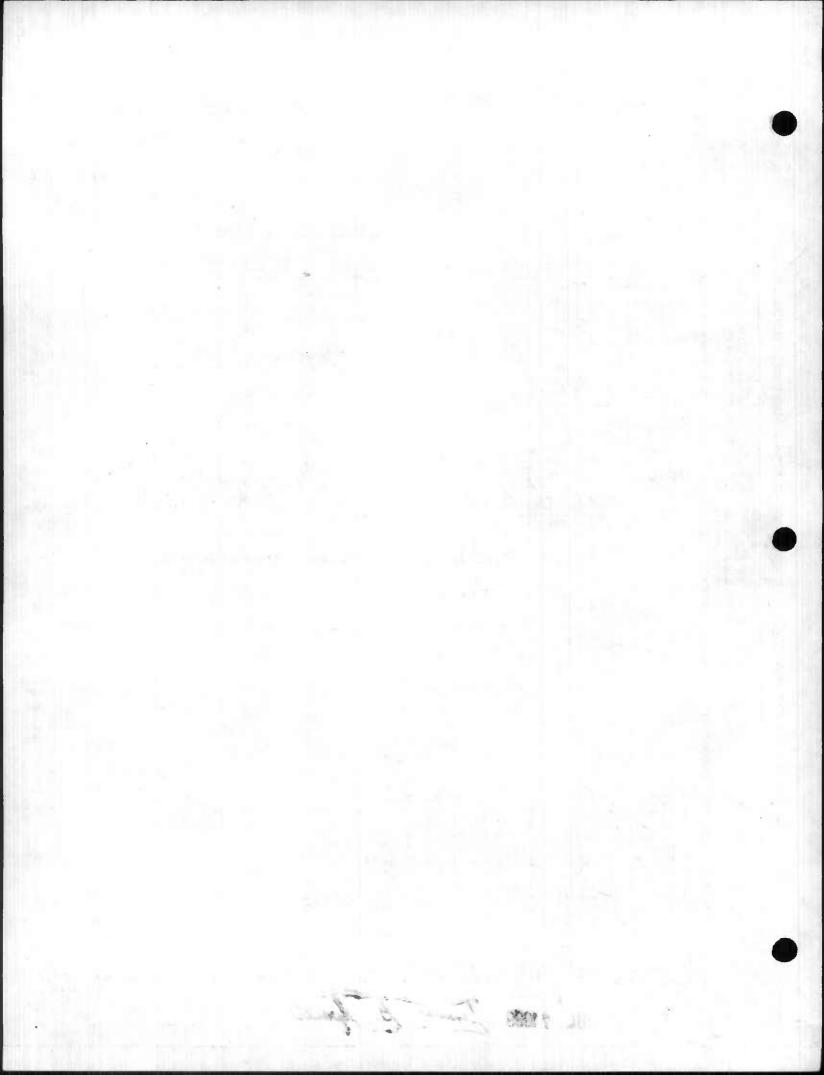
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28h Time of

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)



### Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death 7:00 PM Teith Yaar Month **Physician** Robert 1999 5 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not-institution, giva street and number) 4c. County of Death Examiner Baltimore 10 If Under 1 Yaar If Undar 24 Hrs. 8. Data of Birth Months Days Hours Min. Month Day, 7. Aga (In yrs. last birthday) Birthplaca (Stata pr Foraign **Funeral** 10 M 20 F -82-6976 Yrs. Director Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Xyas 2 No Funeral Director timore 10f. Zip Coda 10e. Street and Number 10g. Citizan of What Country? 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedant Evar in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 11 Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Navar Marriad 2 Married Yas 2 21900 1 Yas 2 10 No 21215-0020 Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced -American Yaar or Datas: HAND Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 12 altimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Be Kei 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) nt of Health a If Illem 27 is or other tra Ray Valerie PI 20b. Place of Disposition (Nama of camatary, cramatory or other) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 ☑ Quriat 2 ☐ Cramation 3 ☐ Removal from Stata 4 □ Donation 5 □ Othar (Specify) more 100 21. Stoffsture of Funaral Sarvice Licensee 22. Nama and Addrass of Fa 650 2222 W. Nori 1. Entar tha saasa, or complications that ceusad tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrest, ck, or heart folium. List only one cause on each line. Approximata Intarval Batween Onsat and Death **Physician** Avium In macellulare /Medical tmmediata Causa (Final Mon the Vwbackerium disaasa or condition rasulting in death) Examiner Dua to (or as a consaquance of): Physician/Medical Examiner ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhisted events resulting in death) Last Dua to (or as a consequence ot): Box 68760 usstance ab Dua to (or as a consequance of): 23b. Did tobacco uss contributs to the causs of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings availabla prior to complation of causa of death? 24a. Was an autopsy performed? Be Completed 2 M 1 Yas 2 No 1 Yas 25. Was case referred to friedical 26. Placa of Death (Check only one) Othar: 4 Nursing Homa 5 Assidence 6 □Othar (Specify) 1 Yes Certification: To 200 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 결 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 1 (Natural Attending 5 Pending 1 ☐ Yas 2 ☐ No investigation 2 Accident 24 hours after deal Funeral Director: Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide b 29a. Certifier Medical 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceusa(s) and mianner stated. å 29d. Data signad (Month, Day, Year) 44658 Sunna Faris ceusa of daath (Itam 23a) (Type, Print) Evelyn Jonalan Chre 16 S Eutaw St. MO 21201 31. Date filed (Movin, State Registrar



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death JULY KIRBY Day LILLIAN 11:15AM ,05,1999 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death HOSPITAL CENTER HARBOR BALTIMORE N/A If Under 1 Yaar | If Under 24 Hrs. | Hours | Min. 5. Social Security Number 7. Aga (In yrs. last birthday) Birthpiaca (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) 1 ☐ M 2 💢 F USA Maryland 220-05-0239 Sept. 22, 1921 Usual Rasidence of Decedant 10d. Inside City Limits 10a. Stata 10b. County 10c. City, Town or Location Maryland 1 Vas 2 No Baltimore City N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 629 E.Clement Street 21230 USA 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yes, Give A Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2 ☐ No Specify: 3. Widowed 4 □ Divorced White 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Home Maker own Home 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Howard M. Roper Blanche V. Hodges 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 1092 Fitz Court Pasadena, Maryland Margaret N.Cook (Sister) 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 Gurial 2 Cramation 3 Removal from Stala Brooklyn Park, Maryland 7/9/99 Cedar Hill Cemetery 4 Donetion 5 Othar (Specify) 21. Signature of Furnaral Sarvice Licensee 22. Nama and Addrass of Facility McCully-Polyniak Funeral Home P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximeta Interval Batween Onset and Death Immediata Causa (Final disaasa or condition resulting in death) 4 DAYS VROSEPSIS Due to (or as a consequance of): 15 YEARS TYPE DIABETES MELLITUS Sequentially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Diseese or Injury that Initieted avents rasulting In death) Last Dua to (or as a consequence of): Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CEREBRO VASCULAR ACCIDENT 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? FAILURE HEART 22 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medicel axaminar? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No 2 ER/Outpatient 3 DOA 28a. Deta of Injury (Month, Day Year) 27. Mennes of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. fnjury at Work? 5 ☐ Panding invastigation **4** ■ Netural 1 Yes 2 No 2 Accidant 6 Could not be datarmined 3 Suicida Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicida

The law requires that the death certificate be exec Box 68760. P.0. Division of Vital Records. or Attending Physician: after death.

**Physician** 

/Medical

Examiner

Directo

Funeral

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**Funeral** 

Director

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Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

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Department of Important: If any injury or

**Physician** 

/Medical

Examiner

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Examiner

Be Completed by Physician/Medical

Certification: To

Medical

29e. Certifier

(Check only one)

29b. Signatura and titla of certifiar

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21215-0020

Baltimore, Maryland

**DHMH 16 Rev 6/95** 

State Registrar

31. Data filed (Month, Day, Year)-

32. Registrar's Signatura 1

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30. Nama and addrass of person who complated ceusa of daath (Itam 23a) (Type, Print)

SRIKANTH RAMACHANDRUNI, MD

BALTIMORE

CHT Certifying Physician: To tha best of my knowledga, daath occurred at tha time, data and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On tha basis of axamination and/or invastigetion, in my opinion, daeth occurred at tha time, data and place, and due to the cause(s) and mannar stated.

29c. Licensa number

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P13132

29d. Data signed (Month, Day, Year)

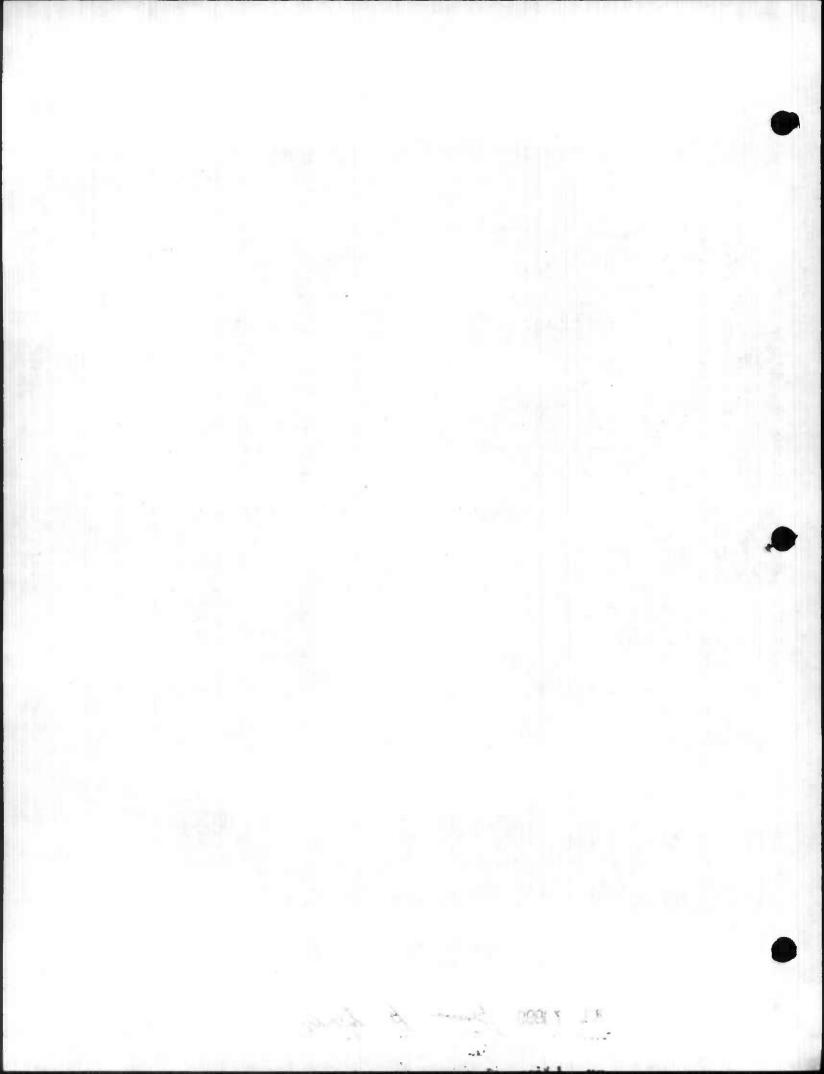
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SOUTH HANOVER STREET

MD

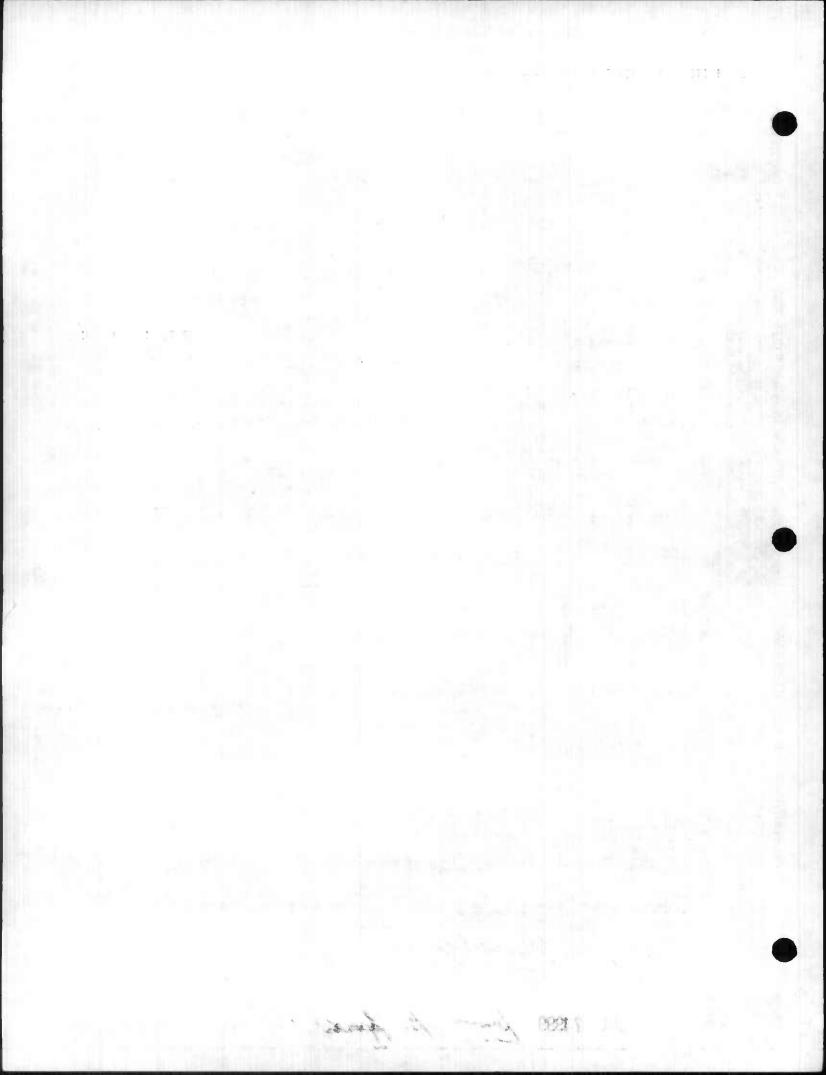
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Physician	EM; #16B PER F.H. G77  1. Decedent's Name (First, Middla,	Last)				2. Data of Dea Month	ath Day	Year	3. Tima of Death 1713 PM
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vith the Marylar to r 28a-f show be notified at Director	10e, Street and Number	.,,11	Darcino	10f. Zip Code			10g. Citizen of \	What Country	y?
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	30. Name and address of person wi Stephen Radent	no completed causa of Z, M.D.	death (Item 23a) (Type 111 Penn	Street,	Baltimore	e, Maryl	and 212	201	
State Registrar	31. Data filed (Month, Day, Year)	*	rar's Signature	- /					

DHMH 16 Rsv 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death t's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** 1999 4:00AM /Medical 4b. City, Town, of Location of Death me (If rjot institution, give street and number) 4c. County of Death Examiner BAYVEEN BALTEMORE N/A If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 ☐ M 2 ☐ F 214-54-4694 85 Yrs Director 9,1913 Dec. Maryland **Usual Residence of Decedent** 10b. County 10c. City, Town or Location 10d. Inside City Limits about 1 Yes 2 No Director Maryland Edgemere 'natural', or hams 23a or 28a-1 Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21219 2327 Lincoln Avenue United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Detes: hours after 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2KNo Specify: White Specify: 3 € Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filled within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5 Years Housewife Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 88 permit. Pages 1 and 2 should be Department of Health and Mental Important: If Itam 27 is marked or any Injury or other traumatic ave Lena Wielicke Mike Brodowski 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Lou Wible / Daughter 2327 Lincoln Ave. Edgemere, Maryland 21219 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ty□ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete /5 ☐ Other (Specify) Oak Lawn Cemetery 7/9/1999 Baltimore, Maryland 21. Signature of doeral Service Lic 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. 21222 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Physician /Medical Immediate Cause (Finel disease or condition resulting in death) NARNOMIN Examiner Examiner AR physician and s the burial-tranait The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): 280 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records, þ 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 ☐ Yes 20 No 1 ☐ Yes 2 ☐ No or Attanding Physician: director, 8 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Npatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? Certification: 5 Pending investigation 1 ENaturel n 24 hours after death... e Funeral Director: Aft bletely filled in by the fur 1 | Yes 2 | No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital edical 29a. Certifier 13 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 16 Rev 6/95

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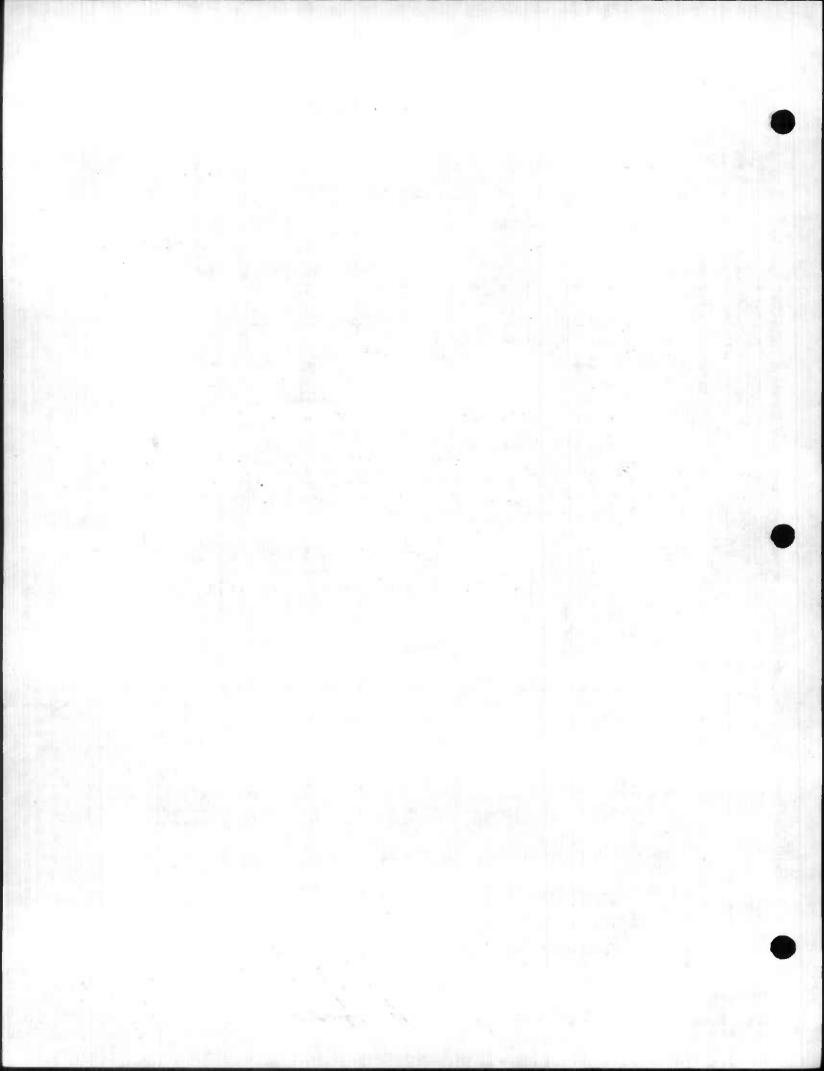
32. Registrar's Signature

30 Mamp and address of person who completed cause of de-

JUL 07 1999

Trace WOO 40

31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

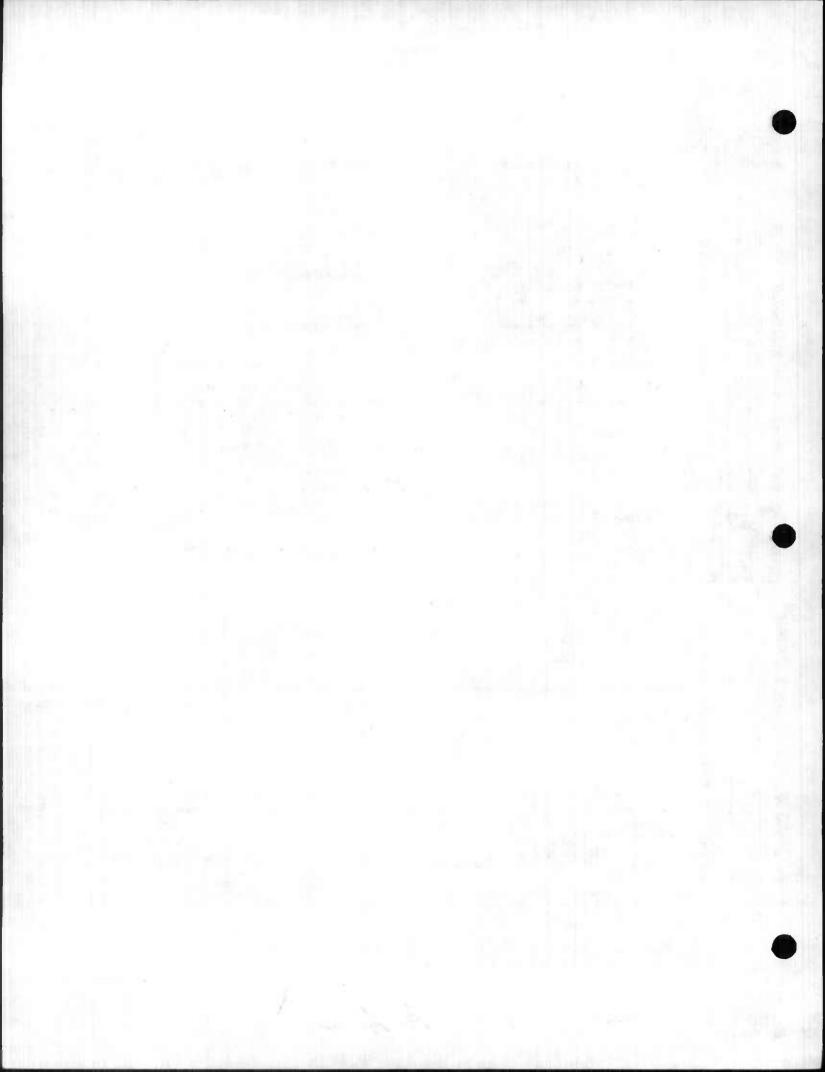
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Certificate of	Death

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Dh	voicion	1. Decedent's Name (First, Middle,						2. Data o Month		ey	Year 3	3. Tima of Death
	ysician Medical	TIMOTHY JOH	IN KRAM	ER					e 30,		9	3:24 P.M
400	aminer	4a Facility Nama (If not institution,	give street and nu	mber)				wn, or Location of E	eath 4	c. County	of Deeth	
		Johns Hopkins Ba	-					imore		N,	/A	
Fun Dire	_	5. Social Security Number 212-48-2867	Sex 1☐XM 2☐ F	7. Age (In yrs. la 5 2	Yrs.	If Under 1 Y Months Da	ear If Under 2 lys Hours	Min. DEC	Birth Day Yea	194	Country	e (Stata or Foraign MD .
p .	es.	Usual Residence of Decedent  10a. Steta 10b. County		10n City	Town or Lo	anting					1104	Santala (Otto - S. Innisa)
e Menyla	ctor	MD. N/A			LTIM						100.	Inside City Limits  1 Yas 2 No
h with th	direction of the following funeral Director	120 N. CLINTO	N STRE	ET		10f. Zip Co	21224			itizen of W	What Country?	?
deat	Jer J	11. Marital Status		edent Ever in U.S	3. 13.	Was Decedent	of Hispanic Orig	in? (Specify Yes o , Puerto Rican, atc.	r No-		- Amarican	
72 hours after death with the Menyland natural", or frems 23s or 28s-f ehow	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed For 1 Test 1 Yes, Gir Year or D	2X No		1 Yes 3		, Fuerto rican, atc	,	Specify	k, Whita, atc. WHIT	
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ental ked o	c ever	GEORGE A. KRA	MER				MAR	Y LEE D	AUGH	ERTY	r	
2 should be filed and Mental Hyg ie marked other	De L	19a, Informant's Name/Relationship			19b. Mailir	ng Address (St		r or Rural Route N				ode)
	other treumetic event,	MARTIN KRAMER	/BROTH	ER	225	S. BC	ULDIN	ST. BAI	TIMO	RE,	MD. 2	21224
00_	iry or oth	20a. Mathod of Disposition  1√CMBurial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe		0. 08	metery, cren	osition (Name of matory or other OF FA	place)	7/3/9			City or Town,	
permit. Pag Department Important: B	any inju	21. Signature of Funeral Service Lic	ensee	1 .	MO	ORAN A	ddrass of Facility	DABROWS	KI F	UNER	AL HO	OME
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certificate be executed ding physician and	se as the bu	that initiated events resulting in death) Last	d	Due to (or	aa a conseq	uence of):					1	
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he law requires that the a has been signed by th	ed by	•					· · · · · · · · · · · · · · · · · · ·		Was an aut			eutopsy findings
law requ	should								performed?		compl of dea	letion of cause
The law	. page 2 should								spect:	LON 25 No		as 2 No
	Be C	25. Was case referred to medical	T				26 Place	of Death (Check o		X		45 20110
	To B	axaminer? 1 Types 2 No	Hospital:	Inpatient 210 E	P/Outpatien	t 3 DOA	Other	rsing Homa 5		6 □Oths	ar (Specify)	
5 5		27. Manner of Death  XX Netural 5 □ Pending	28a. Date	- 22	28b. Time of Injury	28c.	injury et Work?		ibe how in	-		
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i or Attending safter death. I Director: After	ed in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Hornicide determine	d 28e. Place	of tnjury - At hor ng, etc. (Specify)	ne, farm, str	eet, fectory, of	ice		on (Street a Town, Sta		er or Rural R	louta Number,
To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A	edical C	29a. Certifier 1 Certifying ! (Check only one) 20 Medical Ex	eminer: On the be	best of my know asis of examinationer stated.	ledge, death on and/or inv	occurred et th	e time, date and ny opinion, deet	d place, and due to th occurred at the ti	the cause me, date a	(s) and ma	nner es state and dua to the	id. a cause(s)
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DHMH 16 Rev 6/95

Registrar

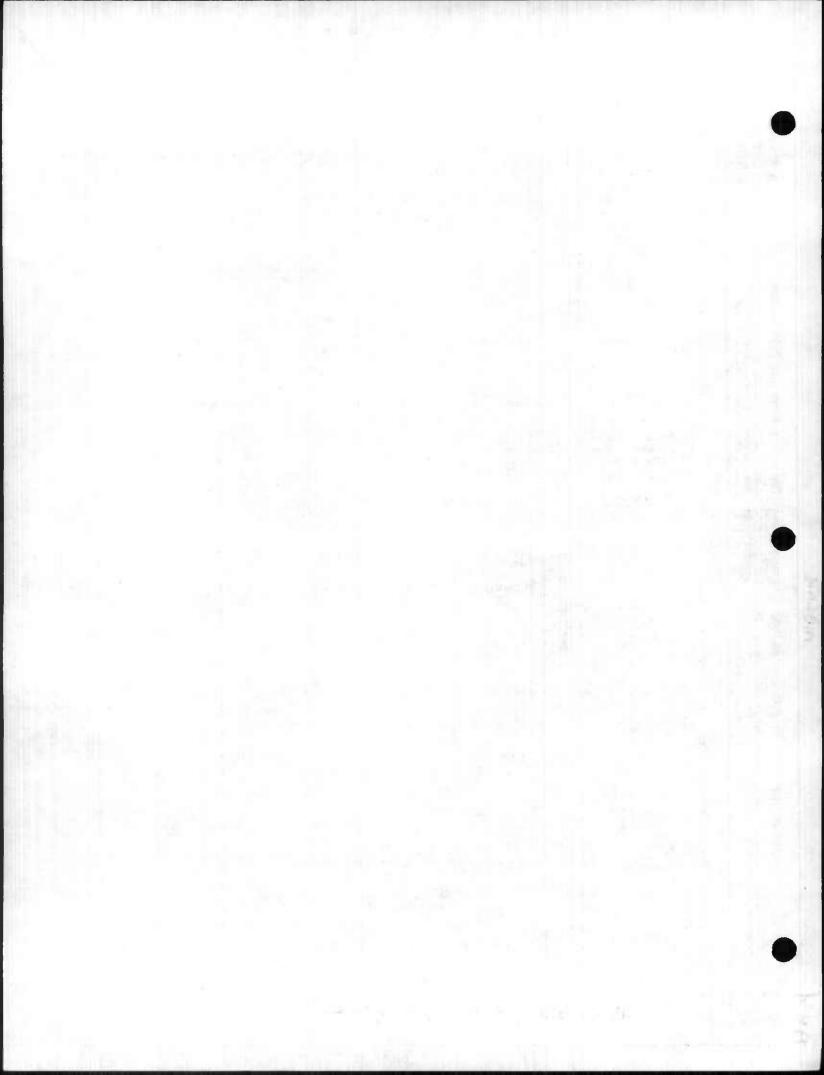
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State of Maryland / Department of Health and Mental Hygiene 99 21292

					Cei	rtificat	e of I	Death			Reg. No.	6	163	6.
	1. Decedent's Name (Firs	it, Middle, La	st)							2. Date of Dec Month		Year	3. Time of	Death
cian lical	Rodney		Lloy	d						July		1999	4:1	5 AM
ner	4a Facility Nama (If not in	nstitution, giv	e street and numbe	or)				b. City, To	wn, or Lo	cation of Death	4c. County	of Death		
	Johns Ho	~	-	w Med	ical				timo		N/A			
1 r	5. Sociel Security Number 218-07-61		ex 7.7 □ M 2□ F	Age (In yrs. le 84		ff Unde Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da NOV 2	y, Year) 1914	9. Birthp Coun VA	lace (State or try)	r Foreign
	Usuel Residence of Dece	11.75		1										
		County			, Town or Lo							1	0d. Inside Cit	
oto	MD B	altim	ore	Ea	gemer	re							1 Yes	2 (S) No
al Director	10a. Street and Number 2508 Wags	ner A	ve			101. Zij	Code 2121	9			10g. Citizen of t	What Coun	try?	
by Funeral	11. Marital Status  1   Never Married 2  3 □ Widowed 4 □ D		12. Was Deceder Armed Force: 1X Yes 2 [ If Yes, Give Year or Dates	s? ] No		Was Dece if Yes, spe 1 ☐ Yas	cify Cuba	lispanic Ori an, Mexicar Specify:	n, Puerto I	city Yes or No- Rican, etc.)		e - Americ ck, Whita, Wh		
ted		ecedent's Ed			16a. Deced	dent's Usu	al Occup	ation	t of working		16b. Kind of B	usiness/Inc	Justry	
Completed	Elementary/Secondary		(1-40 College (1-40	r 5+)				during mos d)	. OF WORKII	79				
Con	0				Stee	elwoi	cker	•			Beth	- S	teel	
Bec	17. Father's Nama (First,										Maiden Suman	ne)		
20	Elzia Lle	oyd						Mar	tha	Brook	S			
THE.	19a. Informant's Name/R	elationship (	Type, Print)		19b. Mailir	ng Addres	S (Street	and Numbe	er or Rura	l Routa Numbe	er, City or Town,	Stata, Zip	Code)	
	Margaret	Dick	inson /	cousi	n 25	808	Vagn	er A	ve	Edge	mere,	MD 2	1219	
	20a. Method of Disposition  1  Buriel 2  Cref  4  Donation 5  C	mation 3		te ce	ace of Dispo metery, crer k Law	matory or o	other plac	•		Data	20c. Location	City or To	wn, State	
	21. Signature of Funeral	ing C.	Connel	200	22	Name ar Conr	ad Address	ss of Facility Y Fu	nera	al Hom	e of D	unda		
Jer.	23a. Part1. Enter the dis- shock, or heart failur Immediate Cause (Final disease or condition resulting in death)	List only	a. Acut Athevo	€ M Due to (or	40 (C	Quence of):	lial	in	if ce	sectio	M Diseas	70	Interval Betwonset and D	leeth Ay
In/Medical Examiner	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last	as, ata	b. File 10	Due to (or	es a consequas a consequal	quence of):	5(())		.5(0)	da )	J15008		500	- Jean
Sicie	Part II. Other algorificant of	conditions	ontributing to death	but not rasul	Iting in the u	nderlying (	ause giv	en in Part I	l,	23b. Did 1	obacco use co	ntribute to	the cause o	of death?
by Physician/										10	Yes 2□No	3 Prol	ably 4 191	Unknown
Completed b										24a. Was perfo	an autopsy med?	av	ara autopsy ti allable prior to mpletion of ci death?	0
0										101	res 2 No	10	Yes 2₩	No
Be	25. Was case referred to	medical						26. Place	of Death	(Check only o	ne)			
70	examiner?		Hospital: 1 Inpa	tient 2 131	R/Outpatien	nt 3 D	Oth Oth	er: 4 Nu	ursing Hor	na 5 🗆 Resid	lence 6 Oth	er (Specif	r)	
	27. Manney of Death  1 Natural 5  2 Accident	Pending investigation	28a. Date of In (Month, E	ijury	28b. Time of Injury		28c. Injun Wor	_	2		now injury occur			
Certification:		Could not be determined	286. Place of I	njury - At hor etc. (Specify)	me, farm, str	reet, factor	y, office		2	28f. Location (5 City or Tox	Street and Numb vn, Stata)	ber or Rura	i Route Numi	ber,
edical	29a. Certifier 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	ertifying Philedical Exam	ysician: To the bes niner: On the basis and manner:	of examination	riedge, death on and/or inv	occurred vestigation	at the tim , in my of	na, data an pinion, dea	d place, a	and dua to tha dead at the time,	cause(s) and made and place,	annar as si and dua to	ated. the cause(s	)
ž	29b. Signeture and title of	certifier		100		29	c. License	e number			29d. Date signe	d (Month,	Day, Year)	
	30. Name and addrass of	7	NUNCE		M D	Print)	D4	5105			July	7, 1	999	
	Afroze M	uneer	, M.D.	901	E. F		Ave	В	alti	more,	MD 21	230		
ate	31. Date filed (Month, Day	7 199	32. Regis	strar's Signati	ure 9.	do	rela	/						

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# Please Type or Print in Black Indelibie Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 Certificate of Death 2. Date of Deeth 1 Decedent's Name (First Middle Last) 3. Time of Deeth Month SHIRLEY LEFTWICH 03-4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) BATTIMORE If Under 1 Year | If Under 24 Hrs. | 8. NA KITCHIE NURSING HOME Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthdey) 10 M 20 F Days Hours Min. 212-44-3206 Usuel Residence of Decedent Yrs. MD 10e State 10b. Count 10c. City\_Town or Location 10d. Inside City Limits Randlles BaH 1 Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 7401 Lesada 21244 Drive 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 500191 Secretar So Adm 12 18 Mother's Name (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) hosalee Vimmie Faison S Maryland 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Somuel Perry McCullough W. Lambard St Balto MD 21223 2527 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Date 1 Buriai 2 □ Cremation 3 □ Removal from Slete 7-8-99 Wood Lawn Cemeter y 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Funeral Services Nath Pille MD 21229 5151 Balto. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Ceuse (Final diseese or condition resulting in death) Smos. Due to (or as a consequence of Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical exeminer? 28. Piece of Deeth (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Harrice 1 inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work?

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

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Director

7 is marked other than "natural", or items 23s or 28s-f shov traumatic avent, the Medical Examinat must be notified at

2 should be filed within 72 hours after deeth and Mental Hygiene.
Is marked other than "natural", or items 23.

permit. Pagas 1 and 2 st Department of Haelth and Important: If Itam 27 ia m any Injury or other traum

Baltimore, Maryland 21215-0020

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Examiner Physician/Medical P Completed Be To

Certification:

Medical

physicien and the burial-transit usa datached f been s Division death. or Attendi after death. Director: A To the Hospital within 24 hours a To the Funeral D

Shirtey Leftwich

Registrar

1 ☐ Yes 27. Manner of Deeth 1 Natural 2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

5 Pending investigation

6 ☐ Could not be determined

28a. Date of injury (Month, Dey Year)

37. Registrar's Signeture

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

281. Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date end piace, and due to the ceuse(s) and manner as stated.
2 Madicat Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred et the time, dete end piece, and due to the ceuse(s) and manner stated.

29b. Signature and the of certifier

29c. License number

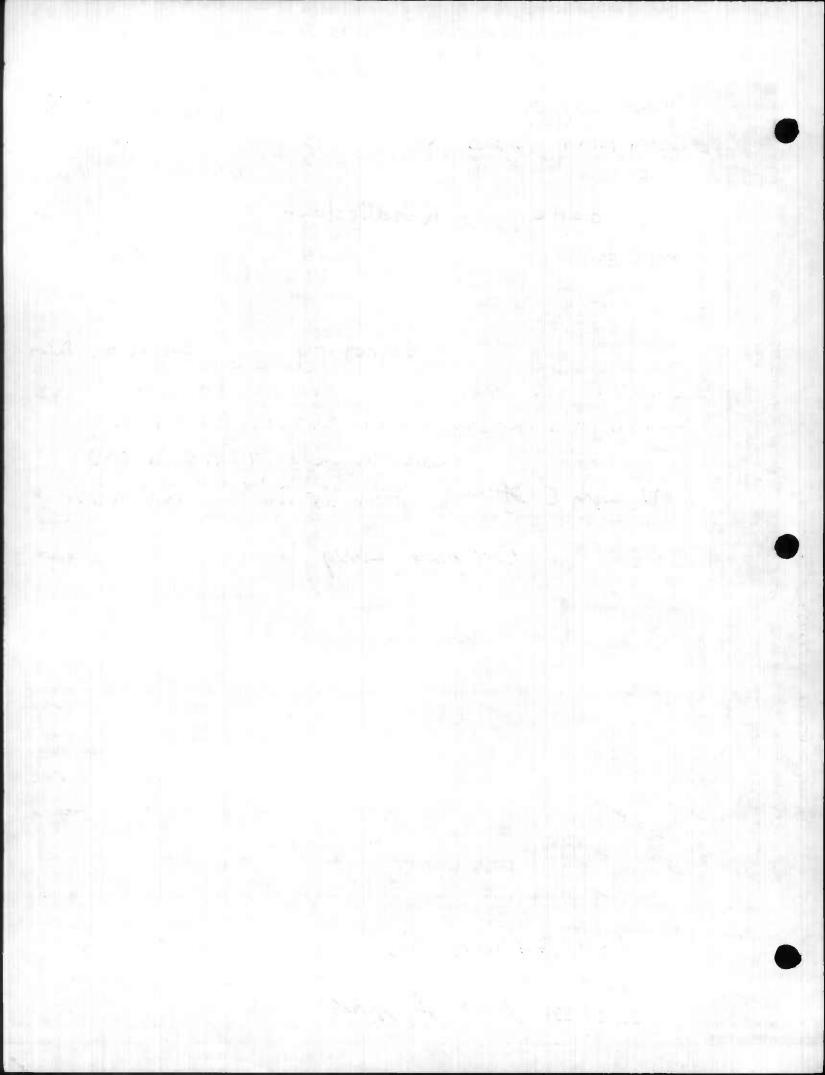
29d. Dete signed (Month, Day, Year)

30. Name and address of person who completed ceuse of death (item 23e) (Type, Print) 0 -VWIA

828 N. Eutaw St. Batter 2,201

31. Date filed (Month, Dey, Yeer)

JUL 07 1999



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) Month Yeer 12-409 **Physician** 1999 JULY 2 Jai Sook Lee /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If not institution, give street end number) **Examiner** len Burnie Arundel Hrundel Anne If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) MAR 20, 19 9. Birthpiece (State or Foreign Country) Korea 5. Sociel Security Number 7. Age (In yrs. lest birthday) 6. Sex **Funeral** Months Deys 1□M 2₩F 88 217-74-1222 Director Usuel Residenca of Decedent 10c. City, Town or Location 10a State 10b. County 10d Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Millersville MD. Anne Arundel 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 21108 USA 496 Brampton Court Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merital Status 14. Rece - American Indien, Black White etc. 1 Never Married 2 Married Korean 1 ☐ Yes 2 ☑ No Specify: Specify: 20 3 ₩ Widowed 4 Divorced Hygiena. other than "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home marked other 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Item 27 is marked or Kyung Soo Lee Kyuna Ho Kim 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Soong Nam Ko - Son-in-law 496 Brampton Ct., Millersville, Md. 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete H. Meadowridge Memorial Park 7/04/99 1X Buriel 2 ☐ Cremetion 3 ☐ Removei from State Elkridge, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility PZI Funeral Service Limpisee Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. tenler the mode of dying, such as cardiac or respiretory errest, 21075 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, shock, or heart feilure. List only one cause on each line. **Physician** STROKE (HAEMORRHAGIC) /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Examiner physician and s the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or es e consequenca of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 SUnknown of the GVER signed b þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en autopsy Completed 2 No 1 Yes 25 No 1 ☐ Yes Hospital or Attending Physician: 24 hours efter deeth. Funeral Director: After this carlifica 25. Wes case referred to medical Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 2 1 Yes 2 No 12 impatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital of within 24 hours a To the Funeral Complately filled Sertifying Physician: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) end menner es steted. 2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signature and title of cartifier 29c. License number MO 051245 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) ARUNDER HOSPITAL

State Registrar **DHMH 16 Rev 6/95** 

the Maryland

and 2 should be

altimore.

Records, P.O. Box 68760

Division of Vital

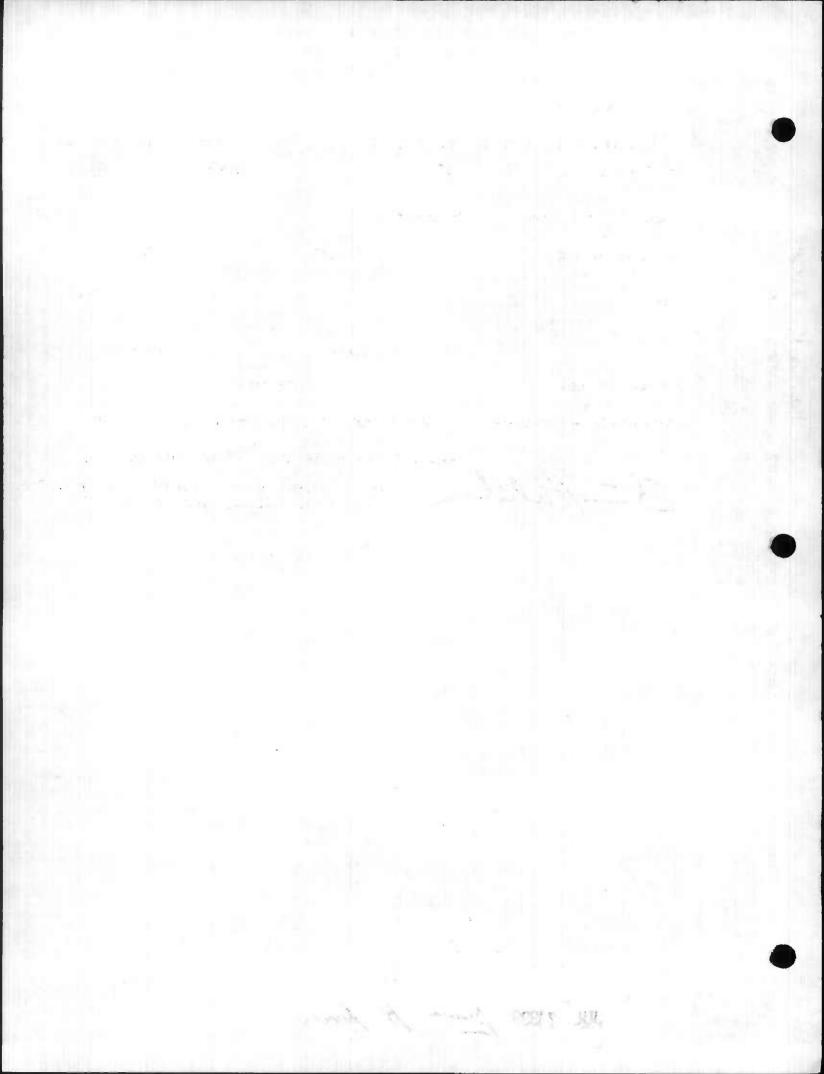
31. Dete filed (Month, Dey, Year).

32. Registrer's Signeture

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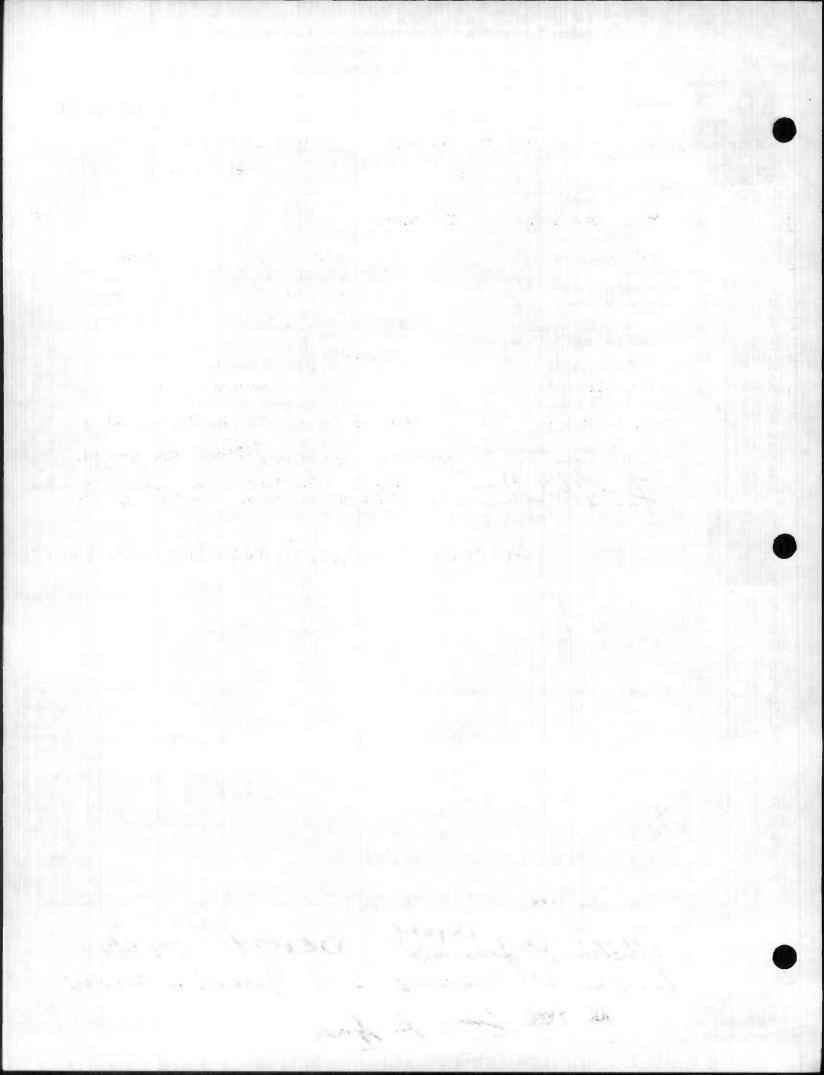
DHMH 16 Rev 6/95

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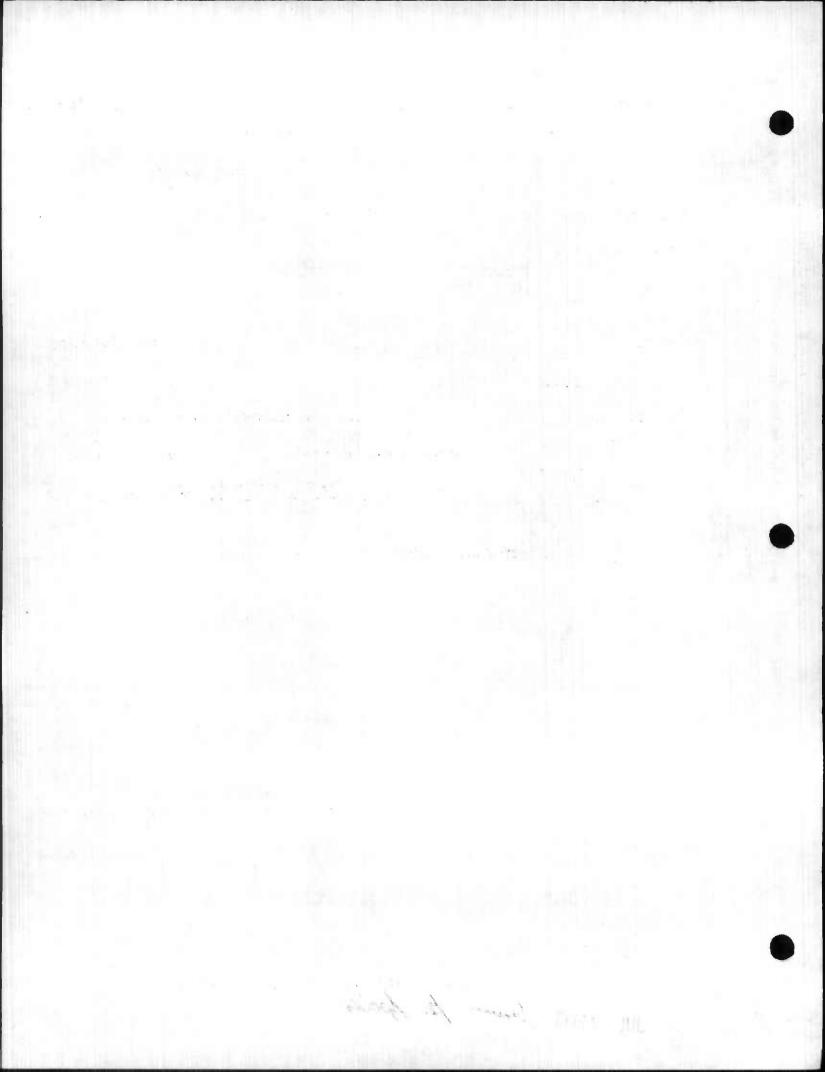
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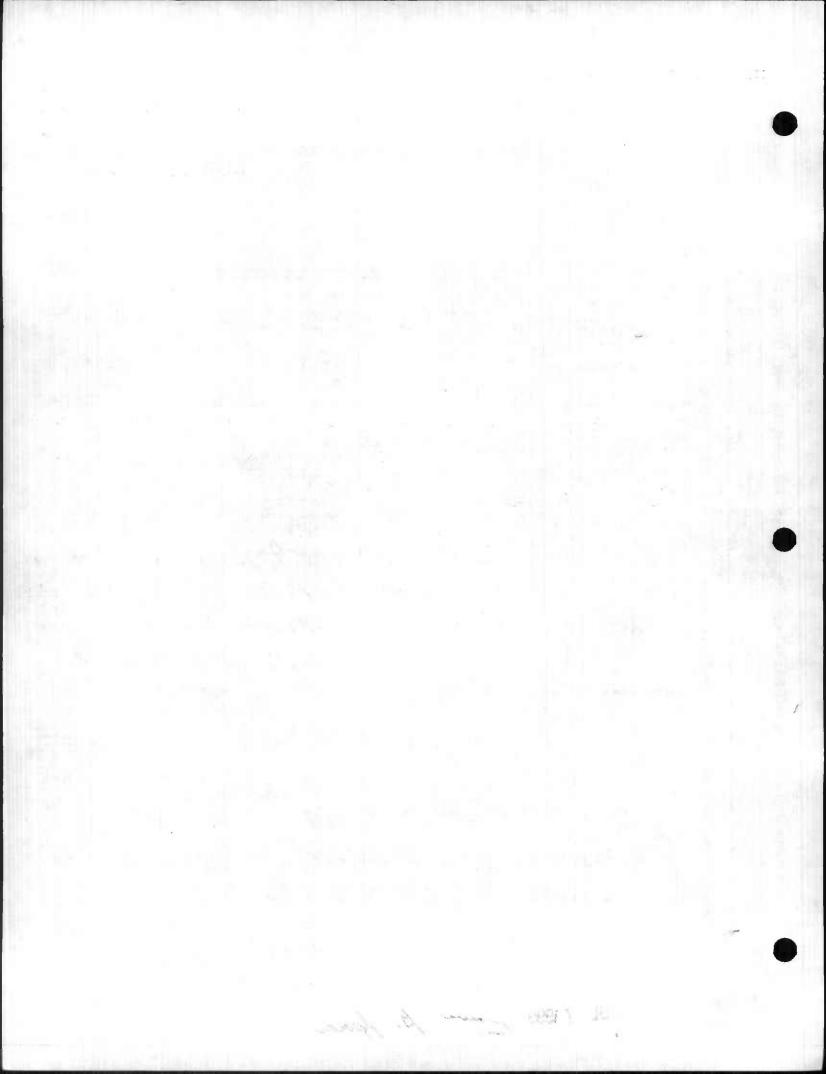
n	Decedent's Neme (Firs	t, Middle, Las	st)						2. Date of Month		ey	Yeer	3. Time	e of Death
	RICHARD  4a Facility Name (If not in	antitution sim	P.	mharl	LY	YONS		lb. City, Town, o	JULY	4	1 1	1999	6:	10 AM
	STELLA MARI			mber)				TIMON		41	c. County	of Deeth	TMORI	E
1	5. Sociel Security Number		ex MM 2 F	7. Age (In yrs	. last birthdey)	If Unde	r 1 Year Deys	If Under 24 Hr Hours Mir	8. Dete of (Month,	Birth Dey, Year	2 _		lece (Ste	te or Foreig
l	212 42 9186 Usual Residence of Dece	dent		24	113.				May	20,19	945		Ohi	0
		County		10c. C	ity, Town or Lo	cation						10		e City Limits
ŀ	Maryland	Balti	more					dlerive						res 2 No
ı	10e. Street and Number 13217 Miles	s Rd.				10/. Zi	p Code	21220	)			What Coun		
	11. Meritel Status  1 Never Married 2  3 Widowed 4 D		12. Was Dece Armed Fo 1 X Yes If Yes, Giv Yeer or D	edent Ever in torces? 2 No ve etes:		Wes Dece if Yes, epe		ispenic Origin? ( In, Mexicen, Pue Specify:	Specify Yes or rto Rican, etc.)	No-		ce - America ck, White, o		
	15. D (Specify only	ecedent'e Ed	ucetion de completed)	W.L.	16e. Deced	dent's Usu	uel Occup	etion during most of w	orkina	16b. I	Kind of Bu	usiness/Inc	dustry	
	Elemantery/Secondery		College (1			Audit		during most of wi f)		Fe	edera	1 Gov	vern	ment
	17. Father's Neme (First, I	Middle, Last)	J1		1,	- Luci C	,01	18. Mother's Na	me (First, Mide	lle, Maide	n Suman	ne)		
	Rowland	Dean		Lyon	S			Elaine	2	E.			Moda	ah1
	19e. Informent's Neme/Re Mary B. Lyon					-		end Number or F d., Mida				State, Zip	Code)	
ŀ	20a. Method of Disposition		ire	20b.	Piece of Dispos cemetery, cren				Dete Dete	7		City or To	wn, Stete	•
	1 Buriel 2 Crent			Stere	cemetery, cremeen Mou				7/99	E	Balti	more	, MD	
	21. Signature of Planeral S				22 C	Name e	nd Addres	ss of Fecility hen D. I n Pastur	ohrman	n P.A	١.			21286
	Immediate Cause (Finet disease or condition resulting in death)		a. AMYO		C LATERA (or as e conseq			SIS					Intervel Onset a	nd Deeth
	disease or condition	s, ete	a. <b>AMYO</b>	Due to (	V - 1111 11 11 11 11 11 11 11 11 11 11 11	quence of)	:	SIS				1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Onset a	nd Deeth
	disease or condition resulting in death)  Sequentielly list condition if any, leeding to immedia cause. Enter Underlying Ceuse (Disease or injury that initiated events	s, ete	a. AMYOT	Due to (	or as a conseq	quence of)	:	SIS					Onset al	nd Deeth
	disease or condition resulting in death)  Sequentielly list condition if any, leeding to immedia cause. Enter Underlying Ceuse (Disease or injury that initiated events	l	b	Due to (	or as a consequence or a	quence of) quence of)	:		23b. D	id tobacc	o use col	ntribute to	Onset ai	nd Deeth
	disease or condition resulting in death)  Sequentielly list condition if any, leeding to immedia cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	l	b	Due to (	or as a consequence or a	quence of) quence of)	:			id tobacc			Onset a	nd Deeth
	disease or condition resulting in death)  Sequentielly list condition if any, leeding to immedia cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last	l	b	Due to (	or as a consequence or a	quence of) quence of)	:		1 24a. W		2□ No	3 Prot	Onset and the cause of the caus	ae of death
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	disease or condition resulting in death)  Sequentielly list condition if any, leeding to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Pert It. Other atgnificant of axeminer?  1 Yes 2 No.	medical Pending	b  c  d  mtributing to de	Due to (	or as a consequence or a	quence of) quence of) quence of) ndertying	ceuse giv	28. Place of Doer: 4 □ Nursing	24a. W	es en eutromed?  Yes  y one) esidence	2 No opsy 2 No 8 XIOth	3 Prot	o the cause of the	as of death IN Unknow sy findings for to of cause
	disease or condition resulting in death)  Sequentielly list condition if any, leeding to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Pert It. Other atgnificant of axeminer?  1 Yes 2 X No  27. Manner of Death 1 X Netural 5	conditions co	b	Due to (  Due to	or as a consequence or as	quence of) quence of): quence	ceuse giv	en in Part t.  28. Place of Dref: 4 □ Nursing	24a. W pe 11 1 1 2 2 4 a. W pe 14 1 1 2 4 a. W pe 15 2 Bd. Descrit 28f. Location	es en eutriormed?  Yes 2  y one) esidence be how inju	2 No opsy  2 No 8 NOth	3 Prot	o the cauchably 4 pere autopailable primpletion deeth?	ae of death IN Unknow sy findings for to of cause
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	disease or condition resulting in death)  Sequentielly list condition if any, leeding to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Pert It. Other atgnificant of a key manner of the cause in	medical  Pending investigation Could not be determined  entifying Physical Exam	b	Due to (  ue to ( Due to	or as a consequence or es ablishment of the consequence of th	nuence of)	ceuse give	28. Place of Does: 4 Nursing 4 at Yes 2 No	24a. W pe 11 seath (Check on Least) 28d. Descrit 28d. Descrit 28f. Location City or e, end due to ti	es en eutridomed?  Yes 2  y one) esidence be how injunt fown, Steine cause(; e, date ar	2 No   3 Prob 24b. We every condition of (specify red)	o the cauchebly 4  ore autopably 4  ore autopable primpletion deeth?  Yes (	ae of death  In Unknow  Sy findings of cause  Un No  SPICE  Vumber,	
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an	F.H. G773 7-7-99			Certificate	e of L	Jeath		Reg. No.	22	21297
1	Decedent's Name (First, Midd     MARGARET)		RINE	LAWSON			2. Date of Dec Month June	Day	Year 999	3. Tima of Death 1:20 P.M.
	4a Facility Name (If not institution	on, give street and num	ber)		4	b. City, Town, or Lo			unty of Death	
	Harbor Ho	ospital Cen	ter			Baltimor	re		N	'A
1	5. Social Security Number	6. Sex 7	. Age (In yrs. last b	Months	1 Year Days	If Under 24 Hrs. Hours Min.	6. Date of Birt (Month, Day	h v, Year)	9. Birth	place (State or Foreigntry)
	217-07-5599	10 M 2AJF	86	Yrs.			AUG. 27,	1912		land
⊩	Usual Residence of Decedent 10a. State 10b. County	v	10c. City. Toy	vn or Location						10d. Inside City Limit
-1	Maryland N/A			Baltimore						Yes 2□N
	10e. Street and Number			10f. Zip				10g. Citizen	of What Cou	ntry?
	1705 Covington					230			ed Stat	
1	11. Marital Status	Armed Ford		13. Was Decede	lent of Hi ify Cuba	spanic Origin? (Spen, Mexican, Puerto	cify Yes or No- Rican, etc.)	14.	Race - Ameri Black, White,	
	1 Never Married 2 Mar Widowed 4 Divorces	If Yes Give		1□ Yes 2	2 □XNo	Specify:		Spe	ecity: V	Mhite
		nt's Education	168	. Decedent's Usual	l Occupa	ation		16b. Kind o	of Business/In	dustry
-	Elementary/Secondary (0-12)	est grade completed)  College (1-	4or 5+)	life. DO NOT use	e retired	luring most of worki	ng			
	10	0		Laborer				Во	X Comp	pany
1	17. Father's Name (First, Middle,	, Last)				18. Mother's Name	(First, Middle,	Maiden Sun	name)	
-	Jacob	Walter	Holmes	5		Mary			Sin	mons
	19a. Informant's Name/Relation					and Number or Rurs				
-	Mr. Calvin J. 1	Taylor, Sr.			under .	n Street	Baltir	nore,	Maryla	and 21230
1	20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation	2 DRomoval from S	comete	of Disposition (Namery, crematory or of	thar nian	e)	Date		on - City or T	
ı	4 Donation 5 Other (5		Dulane	y Valley	Mem	. Gardens	7/2/99	7 Timo	nium	Maryland
8	21. Signature of Funeral Service	Licensee /		22. Name and	d Addres	s of Facility				1
	17/0 -16	10. 11				lyniak Fu				1 1 040
+	23a, Part1, Enter the disease of	r confolications that car	used the death. Do	not enter the mode	St F	ort Avenu	ie Balt	timore	, Mary	Approximata
	23a, Part1. Enter the elsease of shock, or heart failure. Line	one cause on ea	ch line.				. roop natory at			Interval Between Onset and Death
	Immediate Cause (Final	1	2000		/	700				11
	disease or condition resulting in death)	a	2Up 10	1100	V	NH			1	( Lost for
		11	Due to (or as a	consequence of):	1-	11 7			- '	
		b. //	MADI	consequence of):	10	11.1	4		1	
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (or as a	consequence or):		0 1 0	A Are			
ľ	Cause (Disease or injury that initiated events	c. //	18HO PE	THATIVE	- (	ARUE	or ATTO	nes	1	
	resulting in death) Last		Due to (or as a	consequence of):	1.		elese	2		
		d. /	ETADO	10 /	re	DOSIS;	1841	ovou	TIK SH	6C/C
F										
. "	Part II. Other algnificant condition	ons contributing to dea	th but not resulting	in the underlying ca	ause give	en in Part I.				o the cause of deat
	- $        -$	OPD					101	rea 2E-N	6 3 □ Pro	bebly 4 Unkno
							24a Was	an autopsy	24b. W	ere autopsy finding
	9	(1) X	APEVI					med?	av cc	vailable prior to empletion of cause
		U							of	death?
-							1 D Y	es 2 PN	0 1	Yes 20 No
-					Out	26. Plece of Death	(Check only o	ne)		
-	25. Was case referred to medica examiner?		/		Othe	A Nursing Hor	ne 5 Resid	lence 6 🗆	Other (Speci	fy)
	examiner?	Hospital:	patient 2 ER/O		A					
	examiner?	Hospital: 1 2 mg	Injury 28b.	Time of 28	Bc. Injury Work	at :	28d. Describe h	ow injury oc	ccurred	
	examiner? 1  Yes 2 No  27. Manner of Death 1  Natural 5 Pendii 2  Accident investi	Hospital: 1 246 1 28a. Date of (Month, igation	Injury 28b.	Time of 28	Bc. Injury Work	rat (? /es 2 No	28d. Describe h			9
	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendi	Hospital: 1 246   28a. Date of (Month, igation not be injured   28e. Place of 28e. Pla	Injury 28b.	Time of 28 Injury M	Bc. Injury Work	rat (? /es 2 No	28d. Describe h	Street and Nu		al Route Number,
	examiner?  1   Yes 2   No  27. Manner of Death	Hospital: 1 246   28a. Date of (Month, igation not be injured   28e. Place of 28e. Pla	Injury 28b.	Time of 28 Injury M	Bc. Injury Work	rat (? /es 2 No	28d. Describe h	Street and Nu		al Route Number,
2	examiner?  1	Hospital: 1 28a. Date of (Month, igation not be mined 28e. Place o building ng Physician: To the bas	Injury Day Year) 28b.  If Injury - At home, fig., etc. (Specify)  est of my knowledge is of examination are	Time of Injury M arm, street, factory,	Bc. Injury Work 1 1	e, date and place, a	28f. Location (S City or Tow	Street and No m, State)	umber or Rur	stated.
2	examiner?  1   Yes 2   No  27. Manner of Death  1   Death  2   Accident  3   Suicide  4   Homicide  29a. Certifier (Check only one)	Hospital: 1 22mg 1 28a. Date of (Month, 1) 1 28e. Place of building 1 2	Injury Day Year) 28b.  If Injury - At home, fig., etc. (Specify)  est of my knowledge is of examination are	Time of Injury M 28 arm, street, factory, e, death occurred a dd/or investigation, in the street of	Bc. Injury Work 1 1	e, date and place, a	28d. Describe h 28f. Location (S City or Tow	Street and No m, State) cause(s) and date and place	umber or Run d manner as s ice, and due t	stated. o the cause(s)
2	examiner?  1	Hospital: 1 22mg 1 28a. Date of (Month, 1) 1 28e. Place of building 1 2	Injury Day Year) 28b.  If Injury - At home, fig., etc. (Specify)  est of my knowledge is of examination are	Time of Injury M 28 arm, street, factory, e, death occurred a dd/or investigation, in the street of	Bc. Injury Work 1 1	e, date and place, a	28d. Describe h 28f. Location (S City or Tow	Street and No m, State) cause(s) and date and place	umber or Rur	stated. o the cause(s)
2	examiner?  1   Yes 2   No  27. Manner of Death  1   Death  2   Accident  3   Suicide  4   Homicide  29a. Certifier (Check only one)	Hospital: 1 22mg 1 28a. Date of (Month, 1) 1 28e. Place of building 1 2	Injury Day Year) 28b.  If Injury - At home, fig., etc. (Specify)  est of my knowledge is of examination are	Time of Injury M 28  arm, street, factory, e, death occurred a dd/or investigation,	Bc. Injury Work 1 1	e, date and place, a	28d. Describe h 28f. Location (S City or Tow	Street and No m, State) cause(s) and date and place	umber or Run d manner as s ice, and due t	stated. o the cause(s)
2	examiner?  1   Yes 2   No  27. Manner of Death  1   Death  2   Accident  3   Suicide  4   Homicide  29a. Certifier (Check only one)	Hospital: 1 DMing 1 28a. Date of (Month, igation not be mined 28e. Place of building the property of the base and manned are the property of the prope	Injury Day Year) 28b. Injury - At home, finder (Specify)  est of my knowledge is of examination are related.	Time of Injury M 28 arm, street, factory, e, death occurred a dd/or investigation, 129c.	Bc. Injury Work 1 1	e, date and place, a	28d. Describe h 28f. Location (S City or Tow	Street and No m, State) cause(s) and date and place	umber or Run d manner as s ice, and due t	stated. o the cause(s)
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DHMH 16 Rev 6/95

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 99

					Cen	tificate of	Death			Reg. N	lo.			
		1. Decedent's Neme (First, Middle, I	Last)						2. Date of De	eeth		V	3. Time of Deeth	
Phys /Me	ician dical	Florence	Virginia	Lednum					June 2			Year	11:04PM	
	niner	4a. Facility Name (If not institution, g					4b. City, To	own, or Lo	ocation of Dee	-	c. County o	f Death		
		834 East Fort	Ave.				Balt:	imore	e City		N/	A		
Funer	al	Social Security Number 6		e (In yrs. last	birthdey)	If Under 1 Yeer Months Days	If Under Hours	24 Hrs. Min.	8. Dete of Bi (Month, D	rth	c)	9. Birthp	lace (State or Forei	gn
Directo	or -	214-46-1689	1□ M 2√ F	53	Yrs.	Month's Days	riouis	IVIU I.	Oct.23				land	
ъ.		Usual Residence of Decedent							-000,20	,,				
anyta show		10e. Stete 10b. County		10c. City, To								1	0d. Inside City Limi	
88-1	5	Maryland Anne A	runder		Pasa	adena							1 □ Yes 2 XN	0
-0020 hours effer death with the Manyland urel', or frems 23s or 28s-f show is Examiner must be notified at	Director	10e. Street and Number				10f. Zip Code				10g. C	Citizen of WI	het Coun	itry?	
ath v	4	474 Center S				2112	_				SA			
er de	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		13. W	as Decedent of F Yes, specify Cub	lispenic Ori an, Mexicar	igin? (Spe n, Puerto	ecity Yes or No Rican, etc.)	0-		<ul> <li>Americ</li> <li>White,</li> </ul>	an Indian, etc.	
20 sette	by F		If Yes, Give	No	1	□ Yes 2□ No	Specify:				Specify:	r.71a	44-	
hour lear	D D	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:	1 44						101	10. 1 (0.		ite	
laryland 21215-0020 2 should be filed within 72 hours efter death with the Marylan end Mental Hygiene. Is marked other then "netural", or itema 23a or 28a-1 show aumetic event, the Modical Examines must be notified at	Completed	15. Decedent's (Specify only highest of	grede completed)	16	(Give k	ent's Usual Occup aind of work done O NOT use retire	during mos	t of work	ing	16b.	Kind of Bus	iness/inc	dustry	
712 With a	Ę	Elementery/Secondary (0-12)	College (1-4or 5				-,							
The Had	Ö	17. Father's Name (First, Middle, La	0		Facto	ory Work	er 18. Mothe	er's Name	e (First, Middle	B1	ack-A	nd D	ecker	_
Maryland d2 should be file h end Mental Hy 7 is marked othe traumatic event,	Be													
Marylc d 2 should th end Mer 7 is marks traumatic	2	19a. Informant's Name/Relationship		1	9b Mailing	Address (Street			ce Virg					_
Magaga Ma		Elizabeth Plews				Center S							122	
Head Head		20e. Method of Disposition	/Daugitter/	20b. Place	of Dispos	ition (Neme of		Fai	Dete		Location - C			_
no ages		1 Burial 2 Cremation 3				etory or other ple			7/1/00	Dal	timor	o Ma	baclon	
altimore, mit. Pages 1 er pertment of Hea portant: If item 2	-	4 □ Donation □ Other (Special Service Lice)		Ceu		11 Ceme			7/1/99	Dal	CIMOL	e, Ma	Tytanu	-
Baltimore, Maper permit. Pages 1 end 2: Deperment of Health er important: If item 27 la any injury or other treu	5000	111 - 1		/		Cully-Po		•	meral	hom	o D A			
		23e. Per 1. Enter the disease, or co	2 / last	7	1.3	30 E.For	t Ave.	Balt	timore.	Mar	vland	21	230 Approximete	
		shock, or heart failure. List on	ly one cause on each lin	ne.	o not ente	r the mode of dyli	ng, such as	cardiac d	or respiratory t	arrest,	_		Interval Between Onset and Death	
Physicia /Medica	_	immediate Ceuse (Final	^											
Examine		disease or condition resulting in death)	a. Pn	eumon	ia								3 days	
	<u>-</u>			Due to (or as	e consequ	ience of):							3 days	
ned ned	Examiner			statie		,	conce	4					6 month	٥
Box 68760, eath certificate be executed ettending physician and ifor use as the buriel-trensit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (or es	e consequ	ience of):								
68760 ficete be e 1 physician ss the buria	edicai	Cause (Disease or injury thet initiated events	C	Due to (or es	0.0000000	ones of						-		
68 ifficet g phy es th	2	resulting in death) Lest	,	Due to (or es	e consequ	erica ory.						l		
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. 0 0 2	Physician	Pert II. Other significant conditions	contributing to death be	ut not resulting	s in the un	deriving cause giv	ven in Part i	1.	23b. Did	l tobacc	o use cont	ribute to	the cause of deat	h?
D. D. Interpretation of the letache	h X	a some water a real term to the latest at				,							bebly 4 Unkno	
_ 2 0 2	by P													
Hecords, P le law requires thet has been signed b ge 2 should be deta									24a. Was	s an aut	opsy		ere autopsy findings allable prior to	í
w re	Siet								pen	ormed?		COL	mpletion of cause death?	
T 0 - 5	Completed								1□	Yes	2 1 No		Yes 2 No	
VITAL I	BeC	25. Was case referred to medical					29 Place	n of Doeth	h (Check only		2 (2 140		1165 202110	_
	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2 ER/	Outnationt	3□ DOA Oth					6 DOther	/Snacih	Sisters	
O E E E		27. Manner of Death	28a. Date of Injur (Month, Day		. Time of	28c. Inju			28d. Describe		Y		Home	
oth. :: After e funer	atio	1 Netural 5 Pending 2 Accident Investigat		y Year)	Injury		rk?  Yes 2□	No						
VISION Attending or deeth. actor: After by the fune	Hick	3 Suicide 6 Could not determine	286. Placa of Inju	ury - At home,	farm, stre	et, factory, office			28f. Location	(Street a	and Numbe	r or Rura	l Route Number,	
d in Direction	Certification:	4   Homicide	building, etc	c. (Specify)					City or To	wn, Ste	ote)			
DIVISIO  To the Hospital or Attendit within 24 hours after deeth.  To the Funeral Director: All completely filled in by the fu		29a. Certifier 1 Certifying F	Phyalcian: To the best of	of my knowled	ge, death	occurred at the ti	me, date an	nd placa,	and due to the	ceuse(	(s) and man	ner as st	ated.	http://www.
n 24 n 24 ne Fu	edicai	(Check only 2 Medical Expone)	aminer: On the basis of end manner sta	examination a	and/or inve	estigation, In my o	pinion, dea	ath occurr	ed at the time	, date a	nd placa, ar	nd due to	the cause(s)	
Within To the Comp	Σ	29b. Signeture end title of certifier				29c. Licens	se number			29d. D	ete signed	(Month,	Dey, Year)	
		h. Quet	Dad . h	٥		i)	238	09			7/6/	92		
		30. Neme and address of person wh	o completed cause of d	eath (Item 23a	a) (Type, P		-00				70/	1_1_		-
		L. Austo Dayle		ene hav	20	wer Ctr	. 22	S. O	Green	St.	BOL	المسعمية	, MO 2120	0/
5	State	31. Date filed (Month, Dey, Year)		ar's Signature			7			-,-/		THE WAY		
Regi		עע.	1000	www	4	for	1							
DHMH 16 Rev	6/95		200		10.	Book	w							
		Mara			-	-								



### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 22 Fred Henry Levinsky 99 19m 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Bel Air Mariner Health of Bel Air Harford | If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Yeer) | Nov. 29, 1918 5. Sociel Security Number 9. Birthplece (State or Foreign 7. Age (In yrs. lest birthdey) 1**X** M 2□ F Months 217-07-2644 80 Yrs. Maryland Usuei Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🗙 No Baltimore Baltimore Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21236 4205 Soth Avenue U.S.A. 14. Rece - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 11 Marital Status Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WW II 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Defense Manufacturing Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Josephine Czaja Peter Levinsky 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 13536 Fork Road, Baldwin, MD 21013 Mr. Fred Levinsky (son) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State N Buriai 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem'l Gard 7/9/99 Timonium, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home, Inc. 21. Signeture of Funeral Service Licensee Bugn lle 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth Uroscosis Immediate Cause (Final 10 days diseese or condition resulting in deeth) Due to (or es a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Parkinson's D11(411 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Was an autopsy performed? Prostate 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical 26. Piece of Death (Check only one) examiner/ examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. fnjury et Work? 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 1 Naturel 5 Pending

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

Directo

Funerai

p

Completed

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

2 should be filed within 72 hours efter deeth end Mentel Hygiene. Is marked other than "natural", or items 23.

Pages 1 end 2 should be nent of Health end Mentel

or other tr

permit. Page Department of Important: If any Injury or page.

Baltimore, Maryland 21215-0020

the Meryland

with

Examiner physicien end the burief-tren Physician/Medical the ed by the a signed b by Completed peeu Be Certification: To

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, After this certificate has funeral director, page 2 or Attending Physician: n 24 hours efter death.

Ne Funeral Director: Af pletely filled in by the fu

EVINSKY

within 2

completely

Medicai

State

30. Neme and address of person who completed ceuse of death (tem 23a) (Type, Print) 1445 W1/1 31. Dete filed (Month, Dey, Year) 0 7 1999 Registrar

29b. Signeture end title of certifier

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

investigation 6 Could not be determined

and manner stated.

29c. License number D34652

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 Yes 2 No

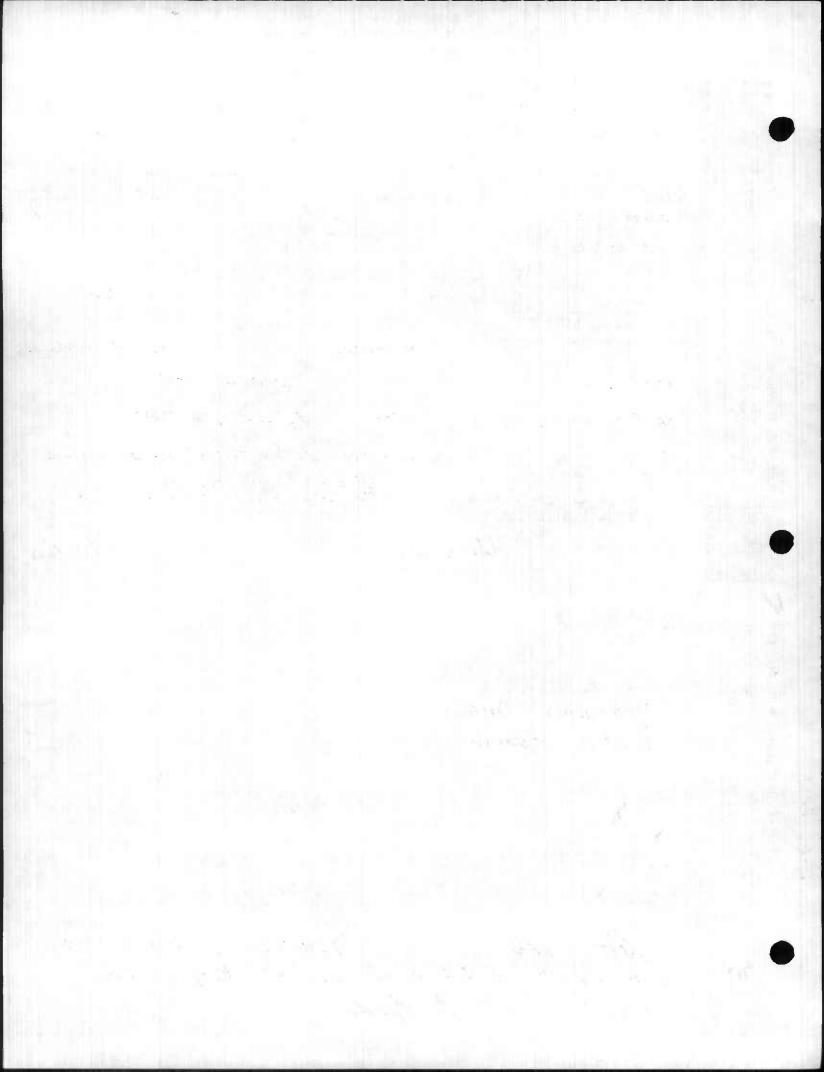
29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Bel Air Maryland 21014

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



# LOWE, WARREN

	Please Type or Print In Black Indelible Ink. Assure State of Maryland / Department of Health and Certificate of Death	-		21300
nysician 'Medical	Decedent's Nama (First, Middla, Last)     WARREN JOSEPH LOWE, JR.	2. Data of De Month	3 Day 19	11 1.0011
xaminer neral ector	FRANKLIN SQUARE HOSPITAL CENTER ROSED  5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 H	in B. Data of Bi	BALT	Death  IMORE  B. Birthplaca (State or Fora Country)  PA.
fled at	10a. Stata 10b. County 10c. City, Town or Location Maryland Baltimore Baltimore Count	;y		10d. Inside City Limi 1 ☐ Yes 💯 ☐ N
on must be notified at uneral Director	10e. Street and Number 9322 Ramblebrook Rd. 10f. Zip Code 21236		10g. Citizen of Wh	at Country?
transfer must by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Evar in U,S.  Armed Forces?  1 Yas, specify Cuben, Mexican, Pu If Yes, Giva  1 Yes or Dates:	(Specify Yas or No arto Rican, atc.)		American Indian, White, atc. White
Completed	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondary (0-12)  12 yrs.  16a. Decedent's Usual Occupation (Giva kind of work done during most of v life. DO NOT use retired)  Lineman	working	16b. Kind of Busi	nass/Industry
To Be C			. Meidan Sumama) ce Scarbo	
er traumat	19a. Informant's Neme/Reletionship (Type, Print)  Mrs. Cheryl L. Lowe  19b. Meiling Address (Street and Number or 9322 Ramblebrook Rd.			
ary or our	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from Stata 4 Donation & Other (Specify) Intombment  20b. Place of Disposition (Nama of cemetary, crematory or other place)  Moreland Memorial Park 7	Data 7-7-99	20c. Location - Co Baltimor	
9500	21. Signature of Funeral Service Licensee  () () (22. Nama and Address of Facility Lassahn Funeral 7401 Belair Rd.		re. Marvl	and 21236
ian ical ner	23a. Part1. Enter the disease, of complications that ceused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.  Immediate Cause (Finel disease or condition resulting in death)  a. Arterioslerotic Corona y Due to (or as a consequence of):			Approximata Interval Batween Onset and Death
Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initieted events rasulting In death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):			
hysi	Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I.  Diabetes MellityS			ribute to the cause of dea
2 2			s an autopsy ormed?	24b. Wera autopsy finding available prior to completion of cause of death?
Page 2	25. Was case referred to medical 26 Place of F		Yes 20 No	1 Yas 2 No
To Be (	examiner? Hospital: Other:	Death (Check only Homa 5 Ras	ona <i>)</i> idence 6 □Othar	(Specify)
completely filled in by the funeral di Medical Certification: To	27. Menner of Death  1 Netural 5 Pending (Month, Day Year)  2 Accidant Solucide 6 Could not be determined 28a. Plece of Injury - At homa, farm, street, factory, office	28f. Location		or Rural Routa Number,
by filled in cal Cert	building, atc. (Specify)  29a. Cartifier (Check only)  1 Certifying Physician: To the best of my knowledge, deeth occurred at tha time, data and place to the deeth occurred at the deeth occurred at the time, data and place to the deeth occurred at the deeth oc	ace, and dua to tha	causa(s) and man	nar as stated.
completely fill	29b. Signature and falls of cutal are  29b. Signature and falls of cutal are  29c. License number  D4776	2	29d. Date signed	
State	30. Name and address of person will complete cause of death (Item 23a) (Type, Print)  Selwyn E, Mahon 9000 Franklin Square  31. Data filed (Menth, Day, Year)  32. Registrar's Signatura	DRIVE	BALTINO	RE MD 2123

DHMH 16 Rev 6/95

State Registrar

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day JULY MARY L. LAMBERT 4a. Facility Name (If not institution, give straat and number) 1999 3 7:05 AM 4b. City, Town, or Location of Death 4c. County of Deeth GILCHRIST CENTER BALTIMORE COUNTY BALTIMORE If Undar 24 Hrs. Hours Min. 5. Social Security Number # Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpiace (Stata or Foreign Country) Months Days Hours 1 □ M 2 ¥ □ F 63 Yrs. 234-54-17B6 July 30,1935 W. VA. Usual Rasidence of Decedent 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits Maryland Baltimore Baltimore County 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1444 Dartmouth Avenue 21234 USA 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas ※XNo If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 1 ☐ Naver Married 2 ☐ Married SpecifyWhite 1 ☐ Yes No Specify. XXWidowed 4 □ Divorced 16a. Decedent's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) Coilege (1-4or 5+) N/A Balto. Gas & Elec. Co. 12 yrs. Clerk 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie N. Gatewood Hassie Wimer 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Robert C. Lambert 7009 Valley Vista Lane Murrysville, Pa. 1566B 20e. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 20b. Plece of Disposition (Name of cametery, crematory or other place) Date 20c. Location - City or Town, State Moreland Memorial Pk. Cem. 7-7-99 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licansee 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a Part Finer the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errast, or heart feilure. List only one cause on each line. Interval Between Onset and Death PANGREATIC Immediate Ceuse (Final (ANCER lhus disaase or condition resulting in death) Due to (or es a consequença of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequenca of) Due to (or as a consequence of) Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? CEREBROVISCULAR 1 Yes 2 No 3 Probably 4 Onknown ACCIDENT 24b. Were autopsy findings available prior to completion of causa of death? HYPERTENSION 24a. Was an autopsy performed? 1 ☐ Yas 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Dothar (Specify) NO SPICE 28e. Date of Injury (Month, Day Year)

Vital Records, 2/3/99 Hospital or Attending Physician: of Division s efter death.

Examiner Physician/Medical Be Completed by funeral After

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Director

Funeral

by

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, tra Magical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after or and or Healih and Mental Hygiene.
Int: If item 27 is marked other than "natural", or iter any or other tranmatic event, II a Marical Exercise.
Inty or other tranmatic event, III a Marical Exercise.

Department of Important: If any Injury or

**Physician** 

Examiner

MARKET, YAR

Baltimore,

To the Hospital of within 24 hours of To the Funeral D completely filled i

filled in by

Certification: To 27. Manyer of Deeth 1 2 Natural

edical

1 Certifying Physicien: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) and menner as steted.
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and plece, and due to the ceuse(s) end manner steted. 29b. Signeture and title of certifier

5 Pending

investigation

6 Could not be determined

29c. License number 030433

1 Tyes 2 No

28c. Injury at Work?

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name end eddress of person cause of death (Item 23a) (Type, Print) NCHMRUES

HALTIMORE

21204

31. Date filed (Month, Day, Year) State Registrar

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier

32. Registrer's Signature

28b. Time of

28e. Piaca of injury - At home, farm, street, factory, office building, etc. (Specify)

**DHMH 16 Ray 6/95** 

Harry Will

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEMS #7 & #8 PER FH G773 7/8/99 AH 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** CHARLES LOGUE 1999 July 2, 9:35 AM /Medical 4a. Facility Nama (If not institution, giva street end numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of Baltimore Gilchrist Center Baltimore Towson Hours Min. 8. Data of Birth Year 1921 9. Birthplace (State or Foreign Country) 7. Aga (In yrs. lest birthday) If Under 1 Year **Funeral** 12 M 2□ F Months Days Yrs. Director 216-14-6224 June 17, 1922 Usual Residence of Decedent 10e. State 10b. County 10c. City. Town or Location 28a-f show 10d. Inside City Limits Director 1 ☐ Yes 2 X No Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 'natural', or Items 23a 14 Blessing Ct. 21234 USA 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 X Yes 2 □ No altimore, Maryland 21215-0020 1 ☐ Yes 2 Ho Specify: If Yes, Give Year or Dates: WW-II by Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then. Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be 2 should be f important: If item 27 is marked F. R. Elmer Logue Annie Bitze1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 14 Blessing Ct. Parkville, Md. 21234 Mrs. Angela Logue/wife 20b. Place of Disposition (Neme of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stata Department of 1 Burial 2 □ Cremation 3 □ Removel from State Deer Park Methodist Cem. 7/6/99 Westminster, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Services 1050 York Rd. Towson, Md. 21204 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Deeth Physician /Medicai Immediate Cause (Final ncrea 7 months; disease or condition resulting in death) Examiner Examir Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Physician/Medical thet initiated events resulting in deeth) Last Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 5 3 Probably 4 ☐ Unknown 1 | Yes 2 | No signed d be del Records, by 24b. Were autopsy findings availabla prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidanca 6 Other (Specify) HOSPICE 1 Yes 2 No 2 27. Manner of Deeth To the Hospital or Attending Pt within 24 hours effer deeth.

To the Funeral Director: After th completely filled in by the funera Certification: 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicida 6 Could not be determined 28e. Plece of Injury - At home, farm, straet, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide

State Registrar

9354

July 2,1999

JAC

31. Date filed (Month, Day, Year) 07 1999

30. Name and address of person who complet

A. Riley

GBMC

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. Licensa number

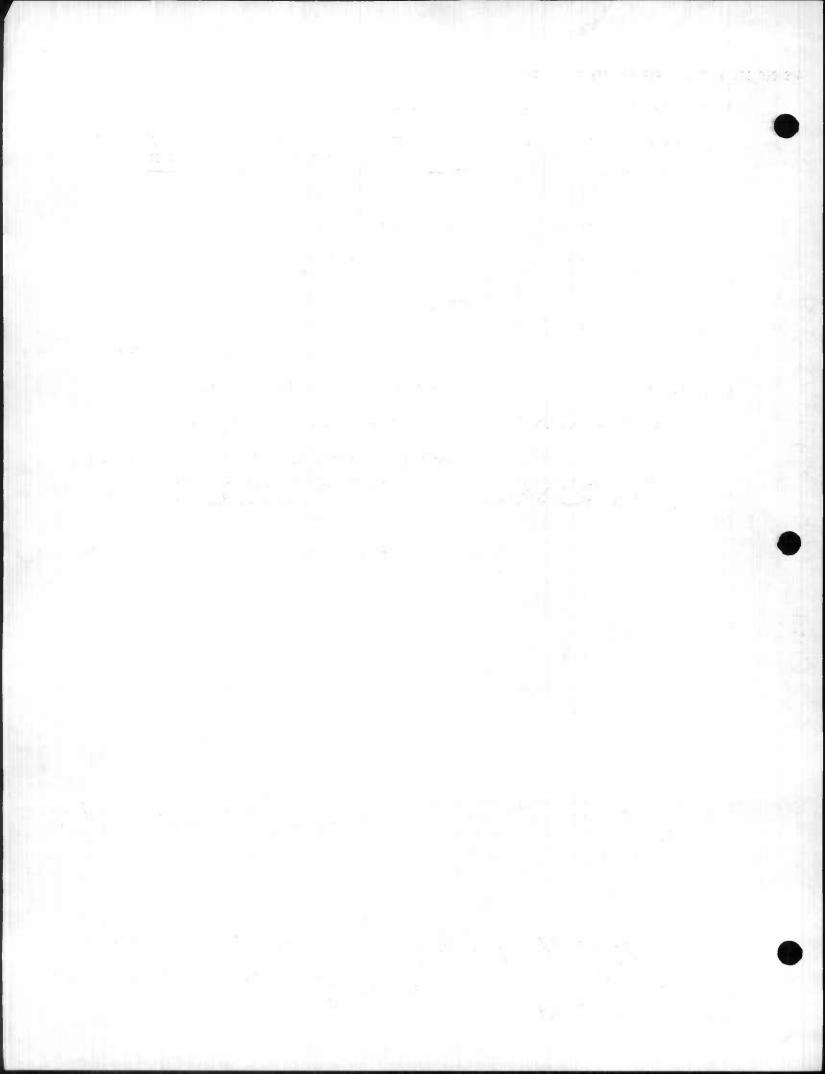
V. Charles St, Baldo, md 21204

D25205

Medicai

29a, Certifier

29b. Signature end title of certifie



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** :40Am ORRISON 1999 JULY 03 /Medical 4h City Town or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number Examiner Howar URSING OLUMBIA DRIAN HOME If Under 1 Year 8. Date of Birth (Month, Day, Year) 10-16-20 Birthplace (State or Foreign Country)
 SC 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 219 - 22 - 8300 Usual Residence of Decedent 1 M 2 F 18 Yrs. Director 10s State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No BALTIMORE Director MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ò Examiner must be Петта 23а USA DRTH Funeral HOUNT OI. 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Meritel Stetus 1 Never Merried 2 Merried of 2 should be filed within 72 hours ath th and Mental Hygiene. It is marked other than "neturel", or i traumetic event, the Medical Exami 1□ Yes 2☑ No Specify: Specify: BLACK 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Home 6 TH GRADE JOMESTIC NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) es 1 and 2 should be III of Health and Mental H I flem 27 is marked off Be BOUKKNIGHT KOSA 2 NATHANIEL UNK t9e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BONNER 9029 WATCHLIGHT VARLENE UMBIA MO 20b. Place of Disposition (Name of permetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition permit. Pages 1 Department of Hi Important: If Iten any Injury or oth 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State KING MEMORIAL 7-6-99 KANDAUSTOWN, MO 4 ☐ Donetion 5 ☐ Other (Specify) ARK 21. Signature of Funeral Se 22. Name end Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATI' PIKE, BALTO. MO. 2 21229 use 23a. Pert1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart half only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel dostreuch re disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner DNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that Initiated events resulting in death) Lest Due to (or es a consequence of): attending physician for use as the buris >0U Physician/Medical Due to (or as a consequence of): USB BS 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown been signed by a p 24b. Wera autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 2/2/10 1 Yes 20 No 1 Yes certificata 25. Wes case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospitet: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Dete of Injury (Month, Dey Year) Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury st Work? 1 Seture 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide

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 Funeral D pletely To the To the To the

Baltimore, Maryland 21215-0020

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide the properties of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29a. Certifie

29b. Signature and title of certifie Saucino 29c. License number 29d. Date signed (Month, Day, Year)

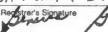
30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

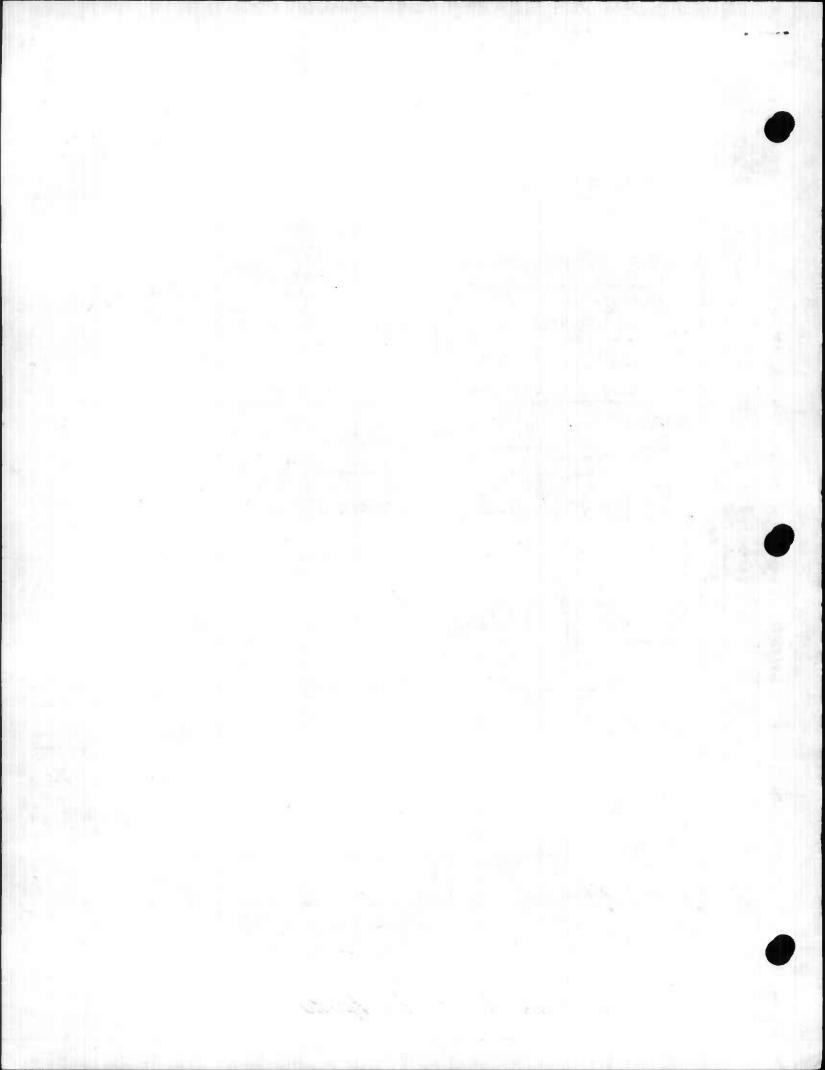
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State Registrar

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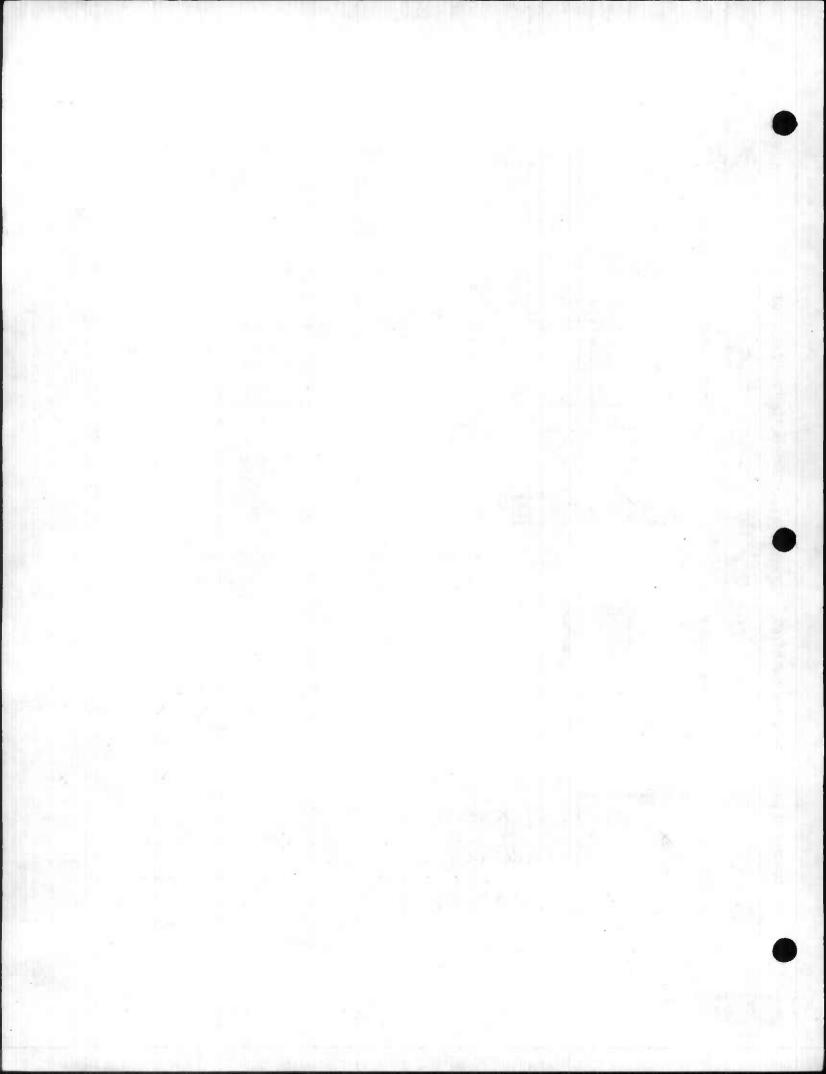




State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death 231 **Physician** Mathews William /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Maryland Mad Center Baltimore University Baltimore 14D If Under 1 Year Months Deys 6. Sax 1 M 2 ☐ F If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (Steta or Foreign Country) **Funeral** 215-34-9109 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or hame 23s or 28s-f ahow the Medical Examiner must be notified at 1 X Yas 2 No Baltimore Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10a. Street and Number US Freedom North Way Funeral Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status filed within 72 hours efter 1 Never Merried 2 Merried 1 Yes 2 No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 ahouid be filed will Department of Health and Mental Hygiens important: if frem 27 is marked other tru any injury or other trearmatic event, trappose. NA 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be 2 Hargrone John 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Matthews KZ 312 Rd-Jaughters Crusader ambreidge 20b. Place of Disposition (Neme of cematery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Cemeter 10 21. Signature of Funerel Service Licensee 22. Name end Address of Facility tuneral Caroline St. 21213 23d. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final Pneumonia disease or condition resulting in death) Examiner Examiner 15 months Strie ca physician and the burlei-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): Division of Vital Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 25. Was case referred to medical examiner? 8 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28a. Dete of Injury (Mgnth, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending Investigation 1 Netural
2 Accident 1:31 after death.

Director: After in by the fun 1 Yes 2 No Aspiration 99 2 6 Could not be determined 281. Location (Street end Number or Rural Routa Number, City or Town, Stele) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide n 24 house the Furneral Direction UNIVERSITY OF MATCYLAND HOSPITAL BALTIMORE, MD edical Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29a. Certifier To the Hose within 24 no To the Fune completary in (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title-of certifiar 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 31. Deta filed (Month, Day, Year)
JUL 0 7 1999 32. Registrer's Signeture State souks Registrar



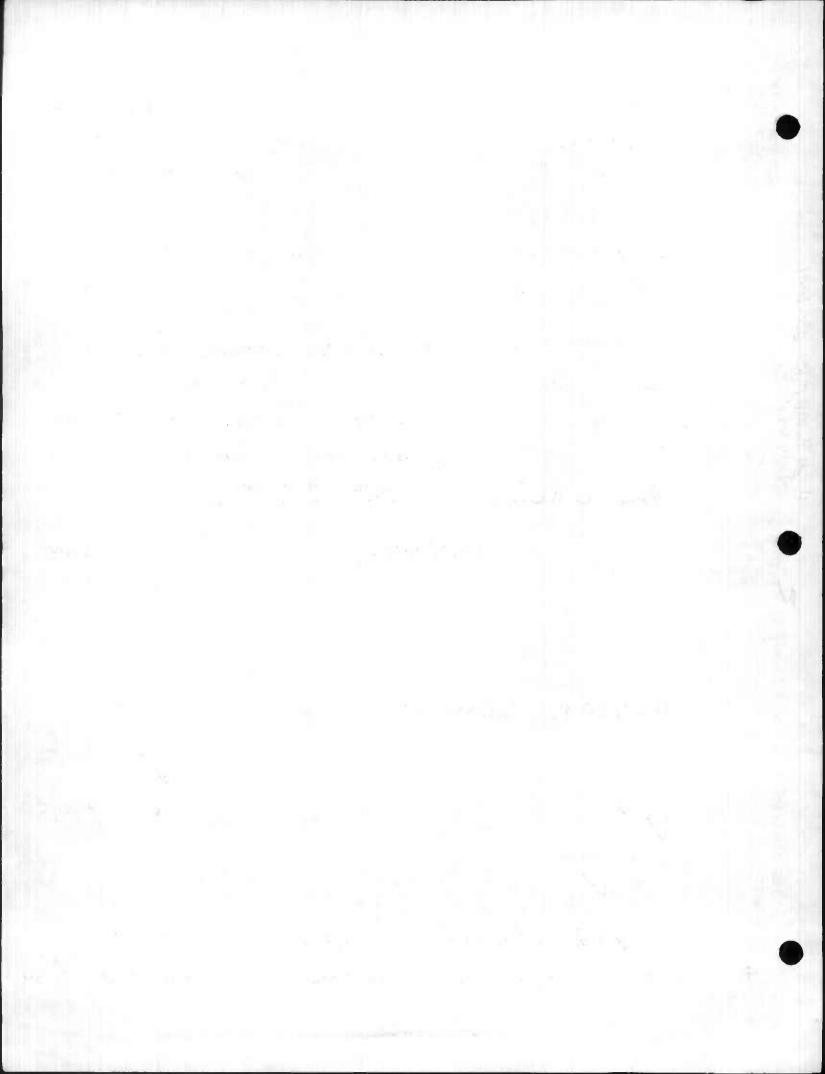
### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Hugh Brent Meyers July 3:59 AM 1999 6, /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 9. Birthplace (Stet County) Nov. 19,1925 Maryland 7. Age (In yrs. lest birthday) Funeral 9. Birthplace (Stete or Foreign Days 1 M 2 □ F Hours 73 Yrs. Director 212-20-7347 Usual Residence of Deceden 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or items 23a or 28a-1 sh Examiner must be notified 1 ☐ Yes 2 XNo Director Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 2518 Perring Woods Road 21234 12. Was Decedent Ever in U,S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 11. Maritel Status Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 M Married Important: If Item 27 is marked other than "neturel", or 1 ☐ Yes 2 X No Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Director of Safety & Security Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Haalth and Mental P. Zink Charles F. Meyers 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2518 Perring Woods Road, Baltimore, MD Corrine Olson Meyers (wife) 20b. Placa of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete Department of 5 XBurial 2 Cremation 3 Removal from State Highview Memorial Gardens 7/9/99 Fallston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, Inc. Busin a Willem 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Intervel Between Onset end Deeth Physician LYMOHOMA 6 Whs Immediate Ceuse (Final diseese or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): physician e the buriel-Box 68760 Physician/Medical Due to (or es a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? o. MYOCHROIML INFARCTION 3 Probably 4 Unknown 1 Tyes 2 No Division of Vital Records, P. Completed by 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 1 Tyes 2 No ai or Attending Physiclen: To s after death. Il Director: Aftar this carificat ed in by the funaral director, ps Be 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) NOSPICE 1 Yes 2 No Hospital: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 1 Di Naturel 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ SuicIde 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide n 24 hours af Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of exeminetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. within 2 the 29c. License number 0 304 33 29d. Date signed (Month, Day, Year) 2 MO of death (Item 23a) (Type, Print) gerson who completed cause 21204 31. Date filed (Month, Day, Year) 32. Registrer's Signature

State Registrar

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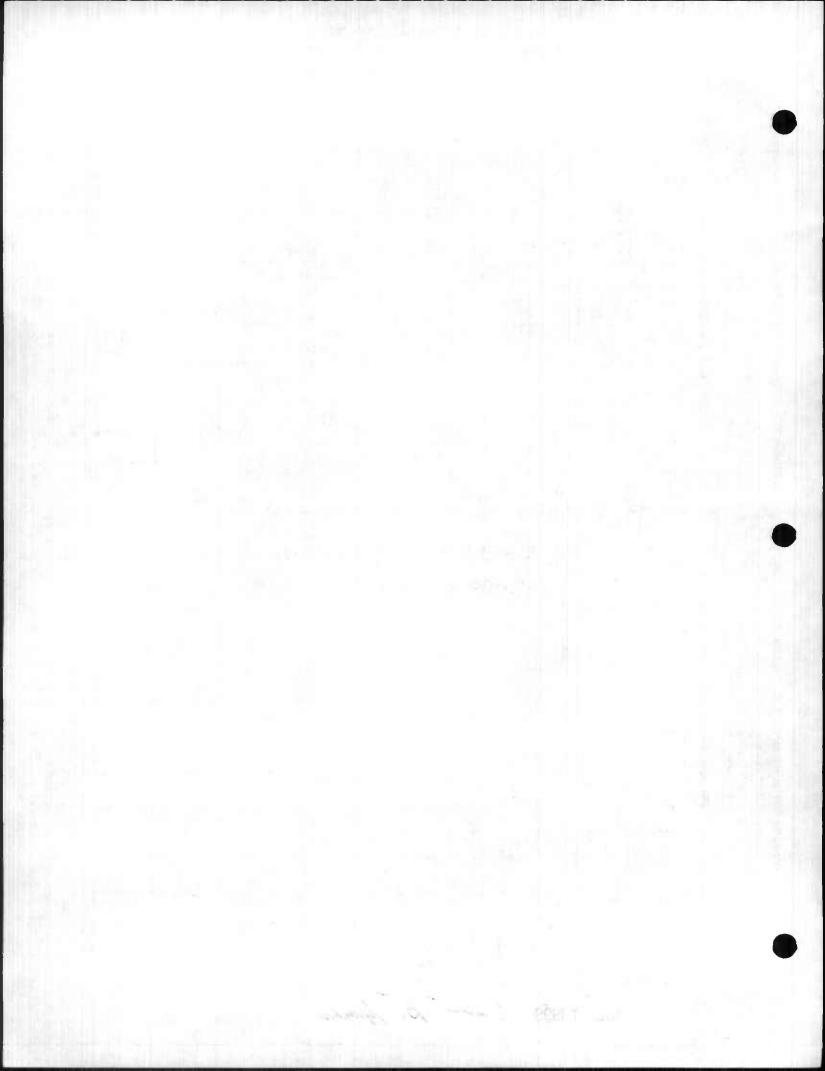
General

B. Sparks



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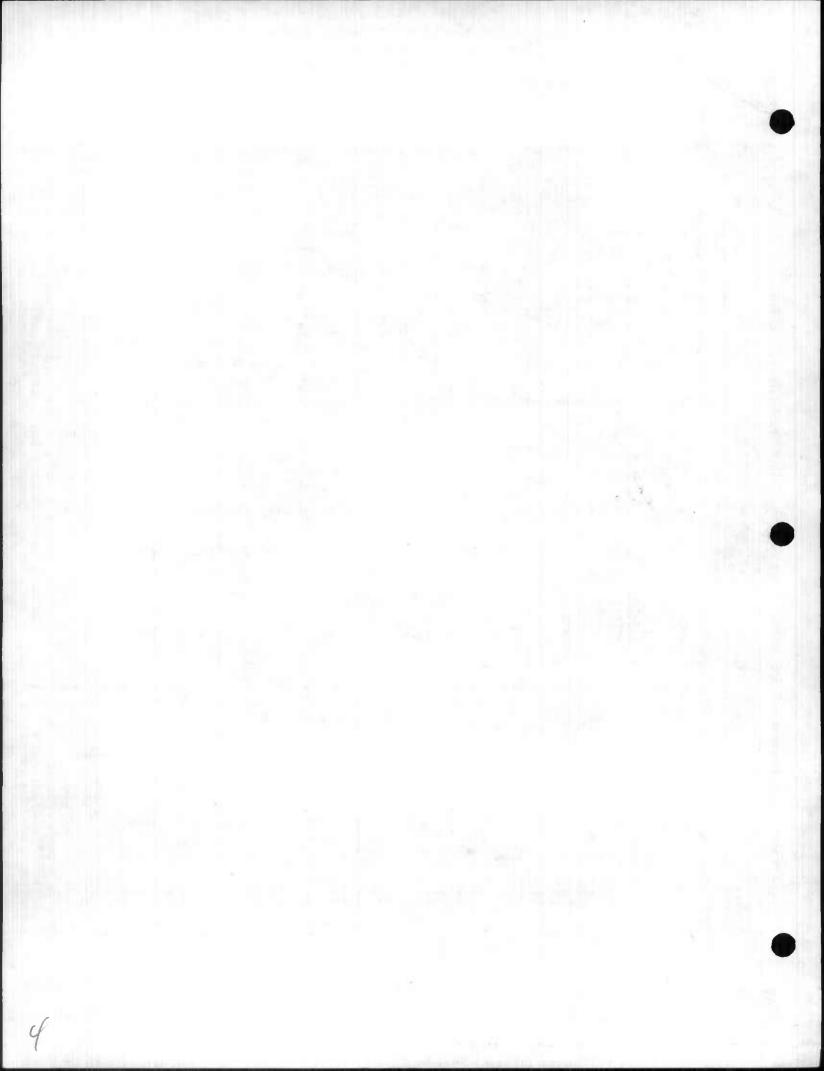
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	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification  Medical Certification		Examiner; On the basis of ex and menner steted	aminetion and/or							
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State of Maryland / Department of Health and Mental Hygiene

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	5. Social Security Number	6. Sex	7. Age (In yrs	last hirthday	If Unde	r 1 Year	If Under		8. Data of Birth			Nana (State or Foreign
uneral irector	213-28-2533	12 M 2□ F			Months		Hours	Min.	(Month, Day	r, Year)		place (State or Foreign stry)
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Completed	15. Decede (Specify only high	nt's Education est grade completed	d)	(Give	dent's Usu kind of wo	vrk done	durina mos	t of worki	ng	16b. Kind of B	Jusiness/Ind	dustry
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0	William Marsh	nall					Ann:	ie Ja	ackson			
	19e. Informent's Name/Reletion	ship (Type, Print)	wife	19b. Maili	ing Address	s (Street	and Numbe	er or Rura	I Route Numbe	r, City or Town	, State, Zip	Code)
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	23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that at only one cause of	caused the dea	ith. Do not en	ter the mod	de of dyin	ig, such as	cardiac o	r respiratory an	rest,		Approximate Interval Between
												Onset and Death
	Immediate Cause (Finel disease or condition	Нуре	rtensive	e Artei	ciosc.	lero	tic C	ardic	vascula	ar Dise	ase	
	resulting in deeth)	a	Due to (	or as a conse	quence of):							
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í	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants	J										
1	Cause (Disease or Injury that initieted evants	С	Due to (	or es a consec	quence of):							
ledical Examiner	resulting In death) Last	1			,							
2		d										
Physician	Pert II. Other significant condit	lone contributing to	death but not rea	culting in the s	indarkina e	Pauca div	on in Part I		23h Did t	obecco use co	ontribute to	the cause of death'
	Total organicant contain	ione contributing to	docum but not rec	sunning an une u	andenyang c	ause giv	OII III T OIL					bably #OUnknow
									101	108 ZLI 140	3   FIG	publy 47/buildion
combiered by									24a. Was a	an autoney	24b. W	ere autopsy findings
									perfor		CO	allable prior to impletion of cause
4									INSPE	ECTION	of	death?
									1 U Y	as 2 X No	10	Yes 2□ No
9	25. Was case referred to medic examiner?						26. Place	of Death	(Check only or	ne)		
2	1X Yes 2□ No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 D	Oth Oth	er: 4 Nu	ursing Hor	ne XXResid	ence 8 🗆 Ot	her (Specif	(y)
	27. Manner of Death 1. Natural 5 ☐ Pandi	28a. Det	e of Injury onth, Day Year)	28b. Time o	of 2	28c. Injur Wor	y at k?	2	28d. Describe h	ow injury occu	rred	
cel IIIIcanon	2 ☐ Accidenf invest	tigetion			M		Yes 2	No				
	3 Suicide 6 Could 4 Homicida deten	mined Zoa. Plac	ce of Injury - At h	nome, ferm, st	reet, factor	y, office		2	28f. Location (S City or Tow		ber or Rura	al Route Number,
	- CITOMOGA	Doir	ung, etc. (Speci	197					Only Or TON	ri, Otaley		
edical	(Check only 2 Medical	ng Physician: To th I Examiner: On the	basis of examina									
Med	one)		nner stated.		100		A language and			20.4 D.4!	-1 (1) (1) -11	A
	29b. Signature end fitte of certific	M	1		29		e number .C.M.I	E.		JUNE 3		
	Woulde	Mey	will			0.	Carrat	•		JOIAN J	0, 19.	
	30. Name and address of person	who completed car	use of death (Item	m 23a) (Type,	Print)							
	Margarita Kor	ell M.D.	1	lll Pen	n Sta	reet.	Balt	timor	e, Mary	rland 2	1201	
tate	31. Dete filed (Month, Dey, Year		Registrar's Sign			4				- La	me V.L	
strar		7 1999	Genera	4	1	20.	1,					



#### Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#1 perPhyG774 8/3/99 EW Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MANGUM PRINCE ROLAND MANDUM JULY 7:10 AM 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death ELDER CARE-LOCH RAVEN TOWSON GENESIS BALTIMORE If Under 1 Yeer If Under 24 Hrs 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 MM 2 F Sept 23, 1932 North Carolina 243-46-1190 66 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits TYPY 2 No MD Baltimore n/a 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21212 4905 St. USA Georges Avenue 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Merital Status ∏XYes 2 No If Yas, Give 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced Year or Dates Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Forklift Operator Gen'1 Service Agency 18. Mother's Nama (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown Mary Mangum 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralallonship (Type, Print) daughter Baltimore, MD 21212 4905 St. Georges Avenue Jean Kent 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurlel 2 Cremation 3 Demoval from State 4 □ Dongtion 5 □ Other (Specifi MD Veteran Cem/Garrison July 8 Owings Mills, Maryland 22. Name and Address of Fecility Nutter Funeral Homes, 21. Signature of Funeral Service Lice 2501 Gwynns Falls Pkwy Baltimore, MD 21216 ع Balcinole, Pib 21216 Balcinole, Pib 21216 and asch ina. Do not enter the mode of dying, such as cardiac or raspiratory arrest, on asch lina. 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final CORONARY disease or condition resulting in death) STACTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) TY PERTENSION Due to (or es a consequence of): 1ABCGE 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Ware autopsy tindings available prior to complation of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 No 1 Yes 26. Placa of Death (Check only one) Other: 4 Universing Home 5 Rasidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner

certificate be executed

Box 68760.

P.O.

Records,

Division of Vital Attending Physicien:

death.

Department of Health at Important: If Item 27 is any Injury or other trau

ä

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

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**Funeral** 

Director

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72 hours after

21215-0020

Baltimore, Maryland

Pages 1 and 2 should be nent of Health and Mantal

lician and burial-transit physician s the burial 500 page 2 certificate this After

Examiner Physician/Medical þ Completed 86 Certification: To To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the f

25. Wes casa referred to medical 1 Yes 2 No

27. Mannar of Deeth 5 Pending investigation 1 Natural 2 Accident

29a. Certifier

Medical

6 Could not be determined 3 Suicide 4 Homicide

28a. Date of Injury (Month, Day Year) Injury 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 Yes 2 No

 Location (Street and Number or Rural Route Number, City or Town, Stata) 1 Certifying Physician: To the best of my knowledge, daath occurred at the time, date and place, and due to tha cause(s) and manner as stated.

28d. Describe how Injury occurred

(Check only one) 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture end title of certifier

29c. License number 52228

E. HORTHERH PKWY

29d. Data signed (Month, Day, Year)

BALTIMORE MD 21214

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) IPULKKMAR BHALODIYA 3007 MD

31. Date filed (Month, Day, Year)

JUL 0 7 1999

32. Registrar's Signatura

State Registrar

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Box 68760, Division of Vital Records, P.O. **Physician** 

/Medicai

Examiner

**Funeral** 

Director

28a-f show

Items 23a

Director

Funeral

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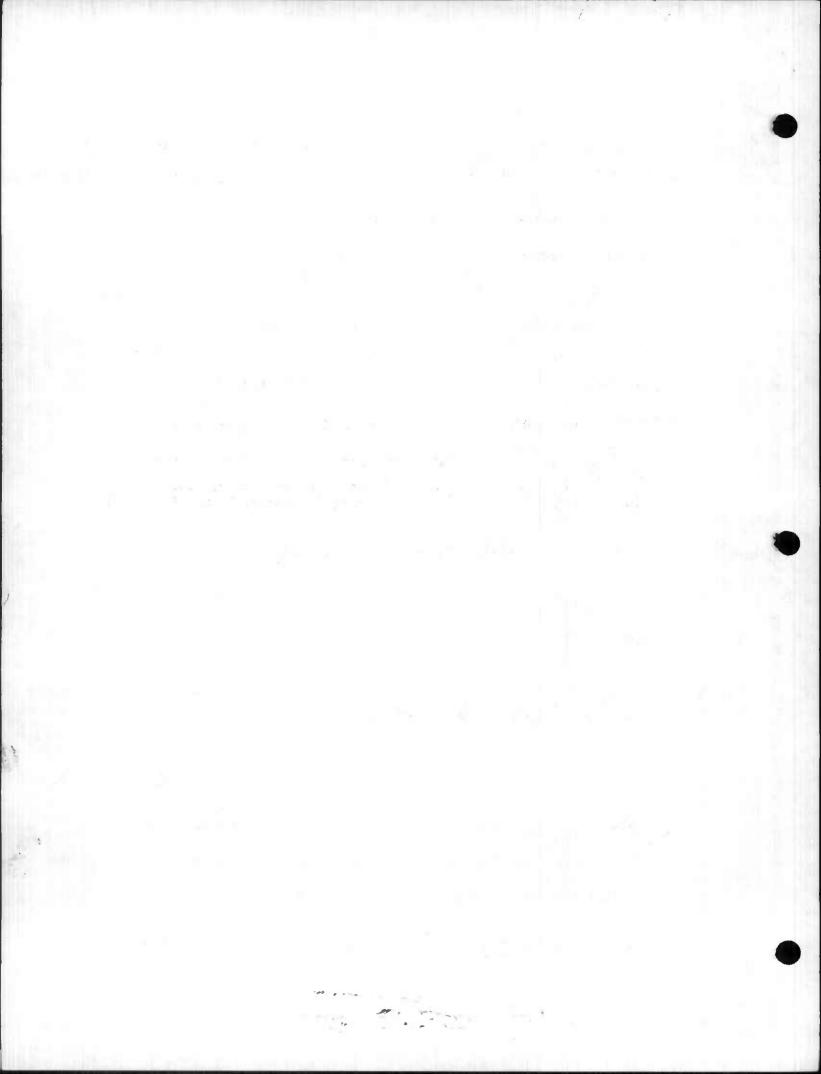
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Baltimore, Maryland

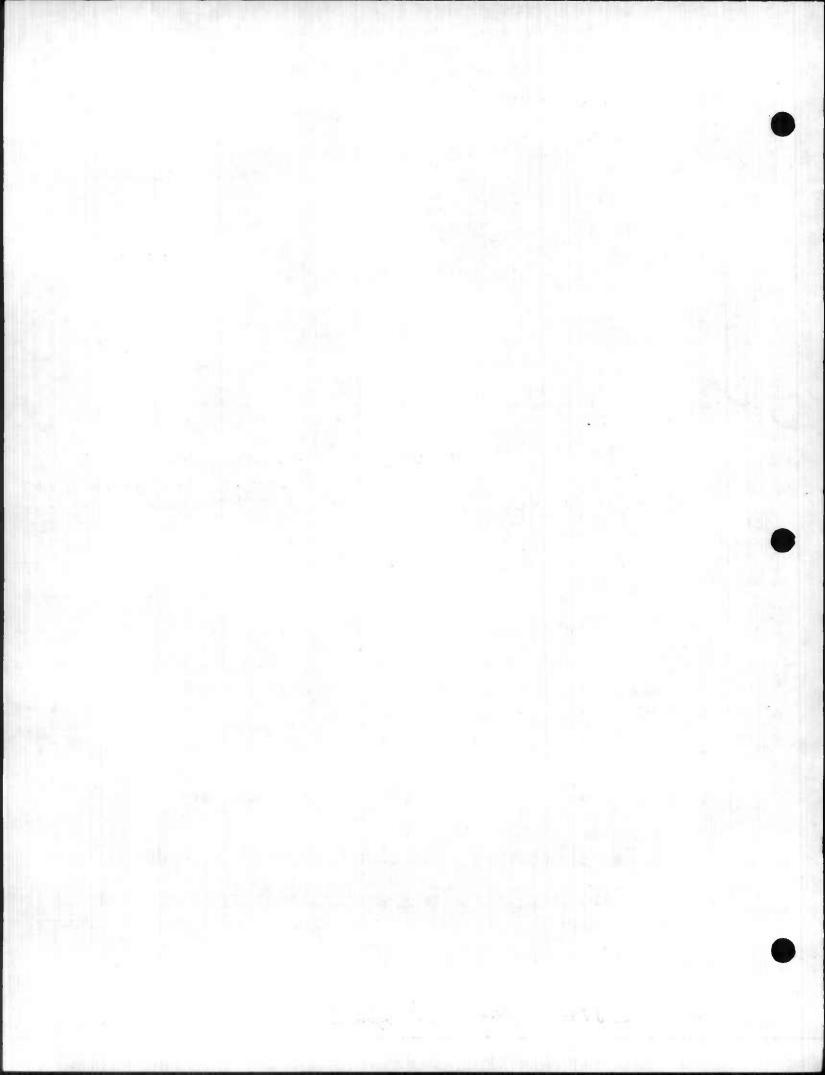
the Medical Examiner must be notified at Pages 1 and 2 should be filed within 72 hours efter death nent of Health and Mentel Hygiena.
nt: If item 27 is marked other than "natural", or items 23. by Completed Elementery/Secondary (0-12) traumatic event. 17. Fether's Neme (First, Middle, Last) Be Albert Smith 19e. Informent's Neme/Reletionship (Type, Print) nt of Health a : If item 27 is or other tra Leigh Cook (Daughter) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donet on 5 ☐ Other (Specify) Department of Important: If any injury or pace. 21. Signeture of Funeral Service Licen-Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only on cause on each line. **Physician** /Medicai Immediate Ceuse (Finel disease or condition resulting in deeth) Examiner Examiner I or Attending Physician: The law requires that the death certificate be executed that death.

Director: After this certificate has been signed by the attending physician end in by the Inneat director, page 2 should be detached for use as the burlet-transit director. Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in deeth) Lest ed by the attending physician detached for usa as the burie Physician/Medical Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. þ Completed Be 25. Wes case referred to medical exeminer? Certification: To 1 Yes Menner of De 1 De Naturei 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Sulcide Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide An 24 hours.
The Funeral Directors of the filled in Hospital 24 hours e Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and pieca, and due to the ceuse(s) and menner as stated. Medical 29a. Certifier (Check only one) medical Examiner: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. To the Vithin 2 29b. Signature 29d. Dete signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause(o) death (Item 23a) (Type, Print)
Peter Graze, MD, 900 Bestgate Rd., Ste 300, Annapolis, MD 21401 31. Dete filed (Month, Day, Year) 32. Registreds Signature, State Registrar



State of Maryland / Department of Health and Mental Hygiene

					Certifica	ate of	Death		Reg. No.	1 6	1310	
Physician		Middle, Last)  T. MILLER						2. Data of De. Month		ă a a	3. Time of Death 1920	
/Medical Examiner	de Caeille Name (Mastine)		umber)				4b. City, Town, or L			y of Death	7 7 7	
Funeral Director	5. Social Security Number 219–05–6743	6. Sex 1√2 M 2□ F	7. Age (In yrs.	last birth	Month:	der 1 Year s Days			th y, Year)	-	laca (Stata or Foraign	
P &u	Usual Residence of Deceder 10a. State 10b. Co. MD 1				or Location	ITY		TILING 1.	7,1726		0d. Inside City Limits 1 □XYas 2 □ No	
TR with the Mary 3a or 28e-f ah at be notified.		AYETTE AVEN	IUE	Ŧ	101. 2	Zip Code	21216		10g. Citizen of U.S.		try?	
MILLE 5-0020 72 hours after death natural, or harm 23 fical Examiner must	3 ☐ Widowed 4 ☐ Div	Married 1 Yes	2 No	J,S.		cedent of Foecify Cub	lispanic Origin? (Sp an, Maxican, Puarto Specify:	pecify Yas or No Rican, atc.)	14. Rad Bla Specif	ce - Amaric ck, White,	etc.	
121215-0 od within 72 ho od within 72 ho ogiene. we than 'reatur	15. Dec (Specify only I Elementary/Secondery (0	) (1-4or 5+)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retin TAILOR		vork done use retire	ccupation one during most of working stired)		16b. Kind of Business/Industry  CLOTHING				
build the same of the control of the	17. Father's Nama (First, Mi						18. Mother's Nam	ne (First, Middle, Maiden Surname)				
Vian Ment by M	JAMES MILLER LOUISE							CODWELL				
NCE , Maryland and 2 should be fite salth and Mertal Hy 72 is marked oth ar traumatic event	19a. Informant's Name/Rela FRANCES MILLE						end Number or Ru					
altimore, mit. Pages 1 a partiment of Hea	20a. Method of Disposition 1 ☐ Burial 2 【XCrema 4 ☐ Donation 5 ☐ Oth	tion 3 Removal from ar (Specify)					∞) 7-5-99 ON-CREMA!	Date IORY	20c. Location			
The law requires that the death certificate be executed that has been signed by the attending physician and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner		b	Due to (	or as a co	2/V onsequence of onsequence of	(): ():	DISEA	SE			years	
death death	Part II. Other algnificant co	nditions contributing to	death but not res	sulting in	the underlying	cause giv	ven in Part I.	23b. Dld	tobacco use co	ontribute to	the cause of death?	
IS, P.O. BOX es that the death cel igned by the ettendir be detached for use by Physician/A		STIVE H							Yes 212 No		bably 4 Unknow	
of Vital Records, Physician: The law requires the certificate has been signeral director, page 2 should be care.								24a. Was perfo	an autopsy med?	ava	ere autopsy tindings ailable prior to mpletion of cause death?	
I Rec								10	ves 20 No	10	Yes 200	
of Vital I hysician: The his certificate il director, pag	25. Was case referred to me examiner?	Hoenitai:	Inpatient 2	] ER/Outs	patient 3 1	DOA Oth	26. Place of Dee	th (Check only come 5 Resid		her (Specify	v)	
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director. Medical Certification: To Be C	27. Manner of Death  1 Netural 5 P  2 Accident In  3 Suicide 6 C	vestigation	of Injury oth, Day Year)		jury M		ry at rk?  Yes 2 ☐ No		how injury occur		al Route Number,	
Div pital or A ours after ours after filled in b	4 Homicide	tifying Physician: To the	e of Injury - At h				mo data and alasa	City or To	vn, Stete)			
Hos 24 hos Fun stely	(Check only 2 Med one)	<b>lical Examiner:</b> On the t	basis of examine oner stated.	etion and	or investigation	on, in my o	ppinion, deeth occur	red at the time,	date and place,	and due to	the cause(s)	
To the within To the complex		ortifier	mid &	pecie		29c. Licens			29d. Date signe			
	30. Nema and address of pa		se of death (Ite	m 23a) (T	Type, Print) N. Bru	adw	40356 Vay, Bal	timere	May	yland	21231	
State	31. Date filed (Month, Dey,	(ear) 32/1	Registrar's Sign	ature 4	1	1			1	/	,	



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Year **Physician** July 1, 1999 James Stanley Mariano 5:00 PM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 47 Waterview Road Dundalk. Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 218-22-2164 8. Date of Birth (Month, Day, Year) March 26, 1928 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days 1⊠M 2□ F Director Maryland Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show inotified at 1 ☐ Yes 2X No Directo Maryland Baltimore Dundalk. 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? must be n 47 Waterview Road 21222 United States Funeral 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after MXYes 2 □ No If Yes, Give Yeer or Detes: WWII 1 Never Married AM Married Baltimore, Maryland 21215-0020 b 1 ☐ Yes ZENo Specify: Specify ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) 12 Years College (1-4or 5+) Steel Worker Steel Industry 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H ant: If Item 27 is marked oth jury or other traumatic even Be Thomas Mariano Eya Lillian Lasek 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Cora Mariano/Wife 47 Waterview Road Dundalk, Maryland 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete Department of Important: If any injury or 4 Donetion 5 Other (Specify) Stanislaus Cemetery 7/6/99 Baltimore, Maryland 22. Name end Address of Fecility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland eeth. Do not enter the mode of dying, such es cardiac or respiretory errest, Physician Immediate Cause (Finel disease or condition resulting in death) Prostate Cancer /Medical year Examiner Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be assecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that Initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Completed by Physician/Medical the Due to (or es e consequence of): for use as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 3 Probably Unknown 1 ☐ Yes 2 ☐ No HTN 24a. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to CAD completion of cause of death? CVOD 1 Yes 2 No 1 Yes 2 No certificate 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 □Other (Specify) Medical Certification: To 1 Yes 22 No 2 ER/Outpatient 3 DOA this uneral 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 1 Neturel s after des. 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and plece, and due to the cause(s) end menner steted. 29e. Certifier (Check only one) 29c. License number 29d. Dafe signed (Month, Dey, Year) 29b. Signature and title of certifier 1 MD 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) B10 merri 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State

**DHMH 16 Rev 6/95** 

Registrar

7 1999

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Death Month July 3, Edna Miller 1999 May 10:40 PM 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Genesis Eldercare- Hamilton Center Baltimore Hours Min. 8. Date of Birth (Month, Dey, May 27, ff Under 1 Yeer 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days 1 □ M 2**X** F Maryland 212-05-9509 93 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 No Mary land N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3614 Ravenwood Avenue 21213 United States Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Black, White, etc. 1X Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) հ Seamstress Hat Factory 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Pauline E. Childress Charles H. Miller 19a, Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mr. Charles H. Neumann / Nephew 3024 Grindon Avenue Baltimore, MD 21214 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Locetion - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corporation 7/6/99 Towson, Maryland 22. Name and Address of Fecility Leonard J. Ruck, Inc. Funeral Home 21. Signature of Funeral Service Licensee Timothy Harman 5305 Harford Road Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In deeth) Due to (or as a consequence of): Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): Due to (or as a consequence of): Pert II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 Tes No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical examiner? 26. Place of Deeth (Check only one) Other: 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 ☐ Residence 8 ☐ Other (Specify) 27. Manger of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work?

**Physician** /Medicai Examiner Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medicai

**Examiner** 

**Funerai** 

Director

28a-f show

Director

Funeral

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Completed

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traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 22 any injury or other traumatic access.

Baltimore, Maryland 21215-0020

the Maryland

Examiner Physician/Medical the þ Completed director, Be 2 funaral Certification:

The law requires that the death certificata be axecuted attending physician ata has been signed by the a page 2 should be detached t this certificata has Attending Physician: After death. or Attendi after death Director: A To the Hospital o within 24 hours at To the Funeral Di

> State Registrar

Medicai

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

5 Pending investigation

6 Could not be determined

Veturel

Accident B ☐ Suicide

4 T Homicide

29b. Signeture and title of

29a. Certifier

32. Registrar's

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Tes

Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end manner as steled.

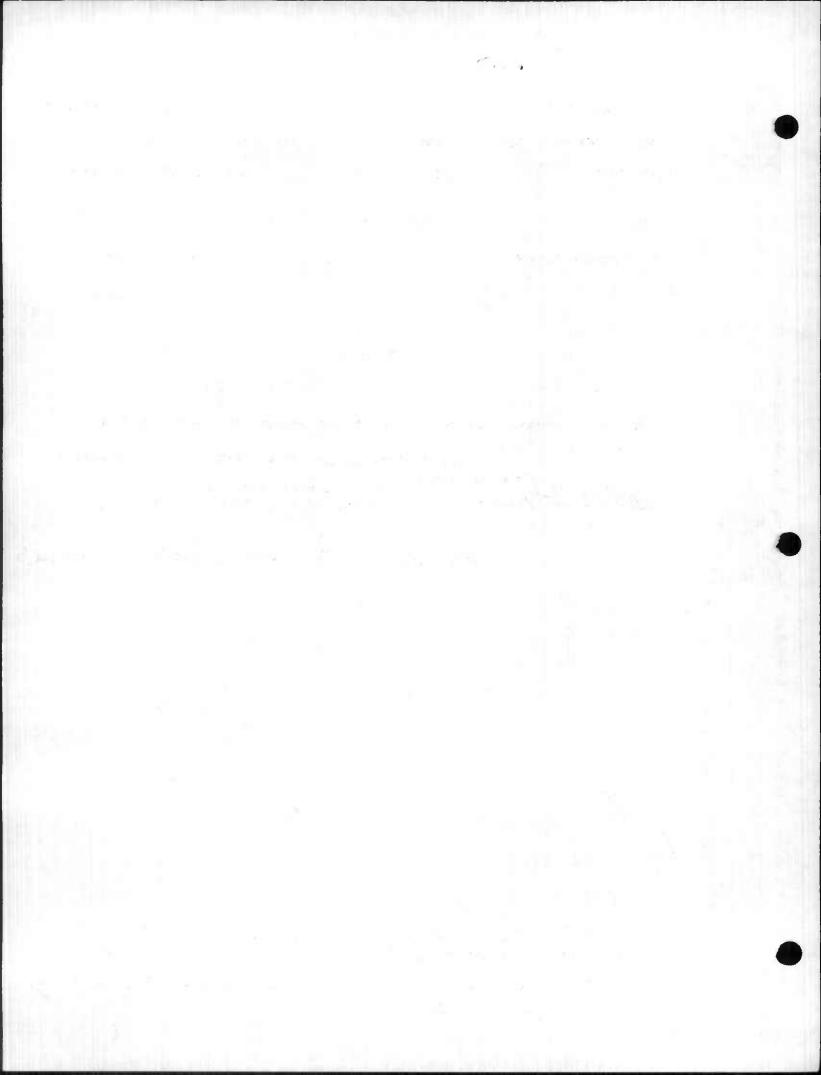
Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

2 🗆 No

29d. Date signed (Mg oth, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)



**Physician** /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hyglene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in Medical Examiner must be notified an once.

Physician /Medical Examiner

Decedent's Nan				Cer	rtificate o	of Death		ene 99	61010
0000001110 11011	me (First, Middle,	Last)					2. Date of Death		3. Time of Deeth
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a Facility Name	(If not institution,	give street and nur	n <i>ber)</i>			4b. City, Town, or		4c. County of	
Stella	Maris F	Hospice @	Mercy			Baltim	nore	NA	
Social Security   216-12	-3602	6. Sex 1 ☐ M 2 ☐ XF	7. Age (In yrs. 76		If Under 1 Yes			Year)	Birthplece (State or Foreign Country)     MD
Jsual Residence of 0a. State MD	10b. County	A		y, Town or Loc altimo					t 0d. Inside City Limits 1 🖔 Yes 2 🗆 No
0e. Street and Nu 1300 E		ale Stre	eet Ap	t.511	10f. Zip Code 21	213	10	g. Citizen of Wh	
	rried 2 Married	Armed Fo	2X No	If	Was Decedent of If Yes, specify C	of Hispanic Origin? (Suban, Mexicen, Puer No Specify:	Specify Yes or No- to Rican, etc.)	Black	- Americen Indian, White, etc. Black
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	(First, Middle, La			Cus	Louian		me (First, Middle, M		)
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To the Hospital or Attending Physician: The lew requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the tuneral director, page 2 should be detached for use as the buriel-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

30. Neme and address of pe 31. Date filed (Month, Day, Year)

29b. Signature end title of certifier

7 1999 32. Regultrar's Signature

em 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

29c. License number

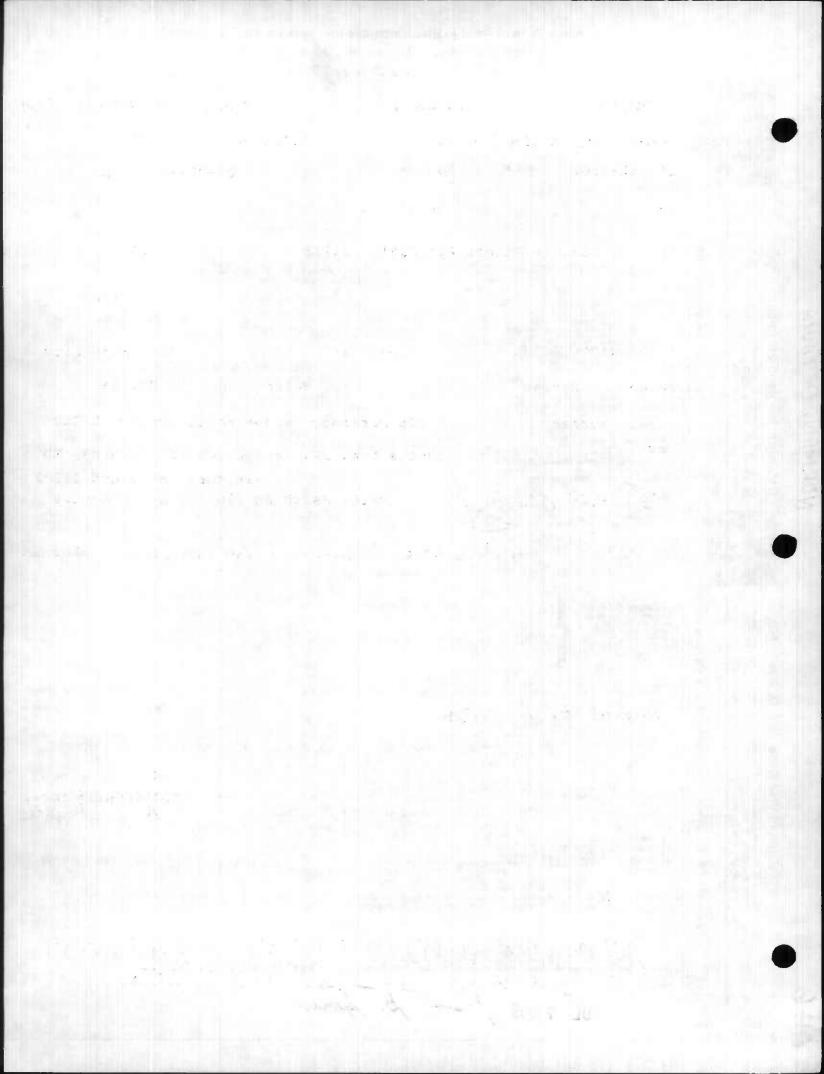
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July 2

J. Omahony, M.B.

Ltoward MD 21202

Aparks

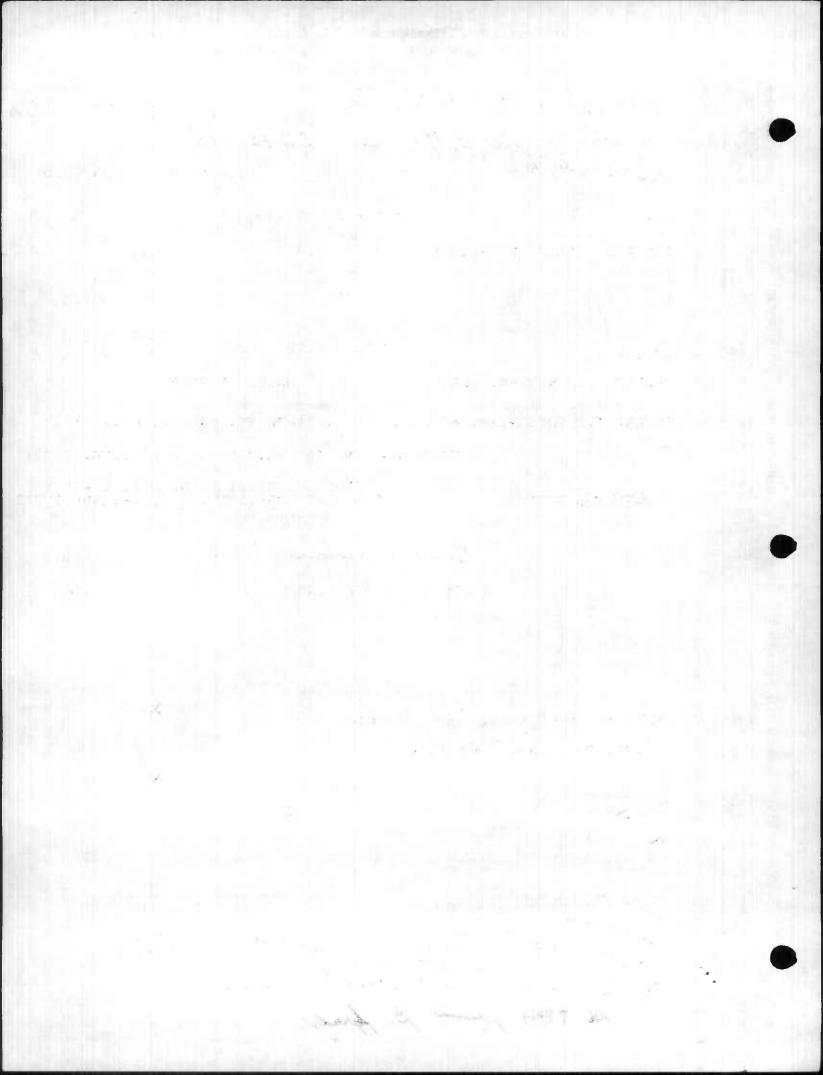


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Dee Month **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death/ Examiner N/A 0 7. Age (In yrs. last birthday) If Under 1 Ye 8. Date of Birth (Month, Day, Year, Birthplece (Stete or Foreign Country) **Funeral** Deys 94 Months 05-18-1905 **Director** MARYLAND the Menyland 10a. State 10b. County r 28a-f show 10c. City. Town or Location 10d, Inside City Limits MD. N/A BALTIMORE CITY XIX Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 7 is marked other than "natural", or items 23s or treumstic event, the Medical Examiner must be a 115 EAST 21212 MELROSE AVENUE U.S.A. Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Maritel Status Black, White, etc. Peges 1 and 2 should be filed within 72 hours after nent of Heelth and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or ite Iry or other treumatic event, the Medical Examines. 1 Yes XXNo If Yes, Give Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes XX No Specify: WHITE by XXWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) FABRICATING Elementery/Secondary (0-12) College (1-4or 5+) IRON WORKER 12 YEARS COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be MARION В. NEWMAN, HARTMAN SR. MARIE 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) RICHARD T. THOMPSON, SR. (NEPHEW) 412 S.GILMOR ST., BALTO., MD., 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State XIX Burlal 2 Cremation 3 Removal from State permit. Pege Department of Important: If any Injury or MORELAND MEMORIAL PK.7-9-99 BALTO., MD., 21234 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility
HENRY W. JENKINS AND SONS COMPANY 21. Signature of Funeral Service Licenses 4905 YORK ROAD, BALTIMORE, MARYLAND, 21212 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest shock, or heart failure. List only one ceuse on each line. Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaase or condition resulting in death) Examiner Examiner Man vears sician and burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 80 use ō signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown muic Obstructive Lune Disease þ 24b. Were autopsy findings evailable prior to completion of ceuse of death? 24a. Was an autopay performed? Completed succetive beart page 2 s 2 No certificate or Attending Physician: Juneral director, Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 70 1 Inpatient 2 ER/Outpetient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 2 Accident 5 ☐ Pending 2 No 24 hours after death. investigetion 1 Yes 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as stated.

| Medical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. edical completely (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and Medical Attend 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) E NelRose MA 112 21212 hwart au C 31. Date filed (Month, Day, Year) 32. Registrar's Signeture

DHMH 16 Rev 6/95

State Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Deeth DENNIS D. O'BRIEN June 30, 1999 7:20 PM 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Baltimore City N/A Mercy Medical Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Dete of Birth 1⊠M 2□ F Months Days Hours Yrs. 217-40-2967 Maryland Sept 26, 1943 Usuel Residence of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland N/A X Yes 2 No Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 11 East Fort Avenue 21230 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indien. Bleck, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Corp. 9 Welder 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) O'Brien James J. Anna M. Guarilla 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 11 East Fort Ave., Baltimore, Md. Maureen C. Poledna (Sister) 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removel from State Cedar Hill Cemetery 4 Donation 5 Other (Specify) 7/2/99 Baltimore, Maryland 21. Signature of Emplishing Licensee Kevin E. Ecker 22. Name end Address of Facility McCully-Polyniak Funeral Home, P.A. 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. 21230 Approximete Intervel Between Onset and Death Immediate Ceuse (Final 405 CIRAHOSIS disease or condition resulting in death) Due to (or es e consequence of): Due to (or es e consequence of): Due to (or es e consequence of) Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 □ Unknown 1 Yes 2 No

**Physician** /Medical Examiner

physician and s the buriel-transit

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been signed by the s should be detached

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certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; s

The law requires that the death certificate be executed

Box 68760.

P.O. I

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permit. Pages 1 and 2 sh Department of Heelth end important: If Item 27 is m any injury or other traum once.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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items 23a

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Pages 1 and 2 should be nent of Heelth end Mental

the Medical Examiner must be notified at

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72 hours efter

Baltimore, Maryland 21215-0020

Examiner Physician/Medical þ Completed Be ၉ Certification:

Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest

24b. Were eutopsy findings available prior to completion of ceuse of deeth? 24e. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Wes cese referred to medical 26. Plece of Deeth (Check only one) Hospitei: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpetient 3 DOA 28e. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) end menner stated. 29a. Certifier (Check only one)

29b. Signeture end title of certif

29c. License number

29d. Dete signed (Month, Dey, Year)

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30. Neme end eddress of person who completed ceuse of death (Item 23e) (Type, Print)

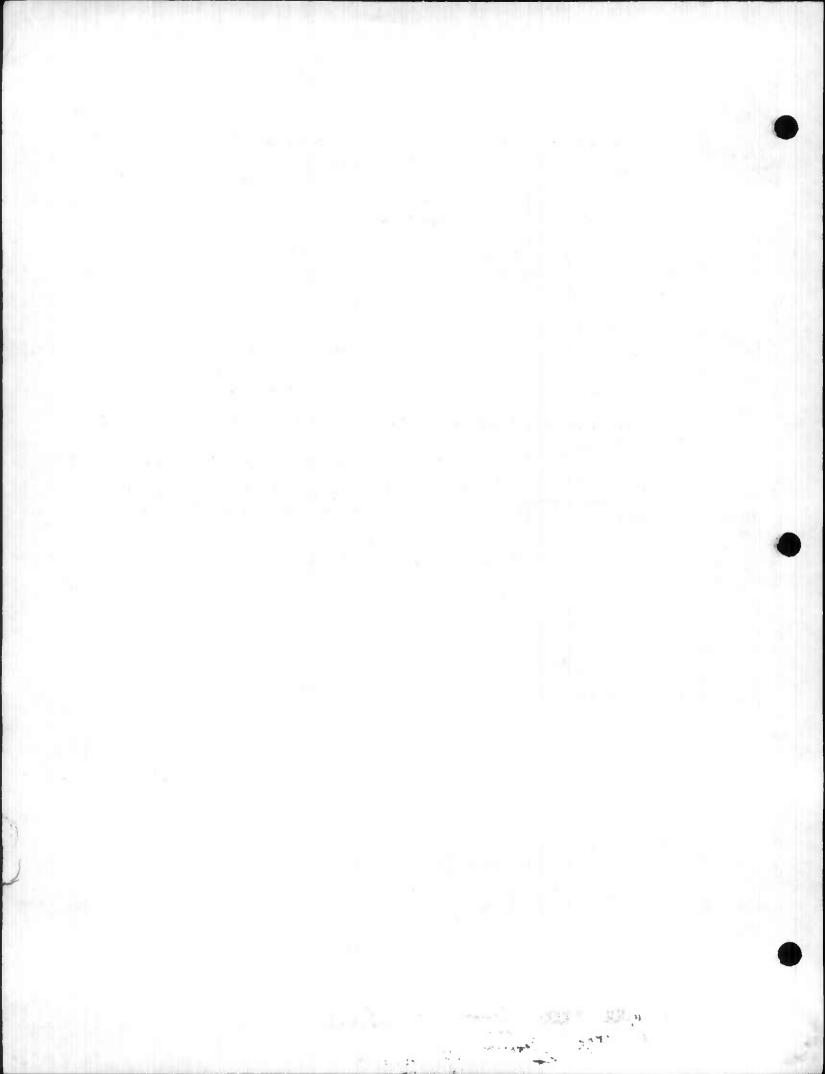
MALC MA OSNER 31. Dete filed (Month, Day, Year)

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State Registrar

edical





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death <sup>Dey</sup> 1999 **Physician** July 1, 12:30 A.M. PRICE LORRAINE TRMA /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Annapolis Anne Arundel Sunrise Assisted Living Home If Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1□M 2X F Months Days Hours Yrs 90 Director 219-01-2741 Maryland Usual Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 26a-f show 1 Yes 2 No Anne Arundel Pasadena Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with United States 21122 236 Old Magothy Bridge Road Pages 1 and 2 should be filed within 72 hours efter death neat of Health and Mentel Hygiene.
Intel filem 27 Is marked other than "natural", or froms 23, mirt if from 27 is marked other than "natural", or froms 13, mry or other traumetic event, in wealton Ecomport main Completed by Funeral 12. Wes Decadent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Bleck, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 White 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) AT&T Company Telephone Operator 8 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Strauss Lowery Lawrence Rosa 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 236 Old Magothy Bridge Road Pasadena, Md. 21122 Mrs. Joyce Schwartz (Daughter) 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 1 ☐ Buriel 2X Cremation 3 ☐ Removel from State Department of important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) Greenmount Crematory 7/2/99 Baltimore, Md. 21. Signeture of Juneral Service Voegse 22. Name and Address of Fecility McCully-Polyniak Funeral Home, P.A. Pasadena, Maryland 21122 3204 Mountain Road 23a. Per 1. Enter the discussions shock, or heart fault. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting in death) Examiner Examiner burief-transit The law requires that the deeth cartificete be executed Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last Box 68760. 5 Physician/Medicai USB ate has been signed by the etter page 2 should be detached for u Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 Yes 2 No Records, þ Completed 24b. Were eutopsy findings available prior to 24a. Wes en eutopsy performed? completion of cause of death? 1 Yes 2 No certificate Division of Vital or Attending Physician: director. 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Assisted exeminer? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA LIVIT this funerai 27. Menner of Deeth 28d. Describe how Injury occurred 28b. Time of 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? Residence After Neture 5 Pending 1 TYes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide Hospital edicai Certifying Physicien: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end plece, and due to the cause(s) end manner steted. 29a. Certifier (Check only one) ş 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

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32. Registrer's Signeture

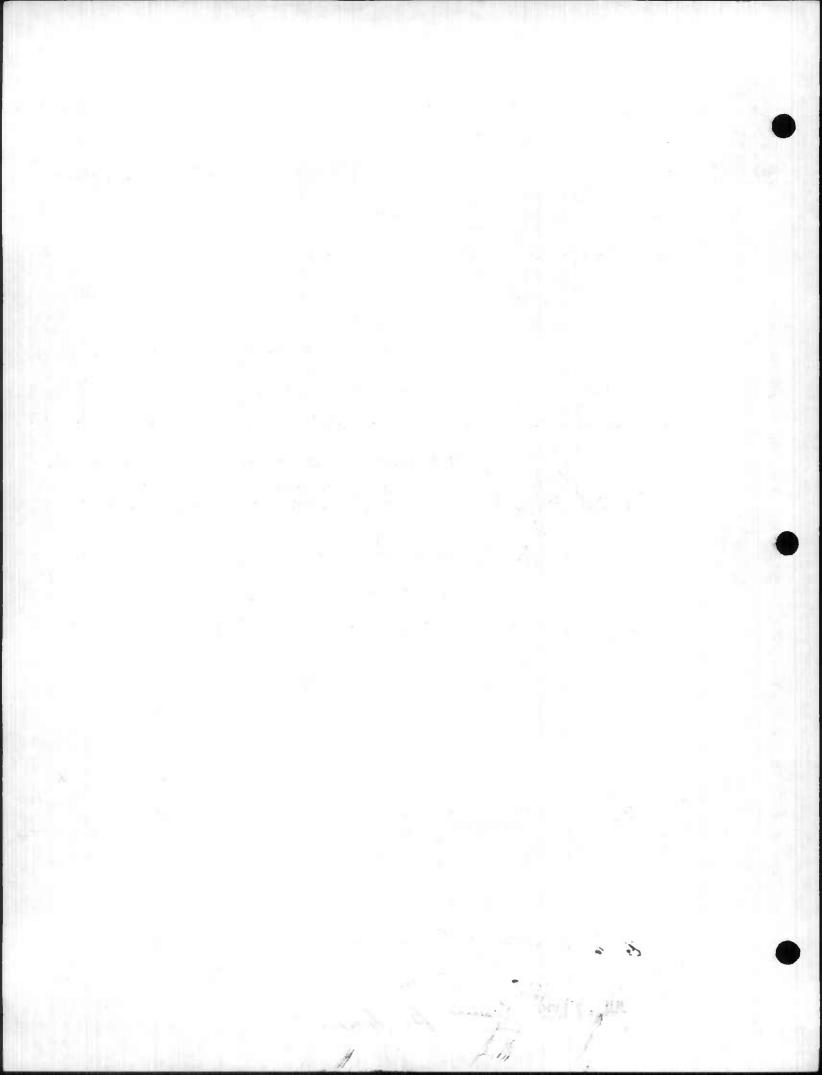
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State Registrar

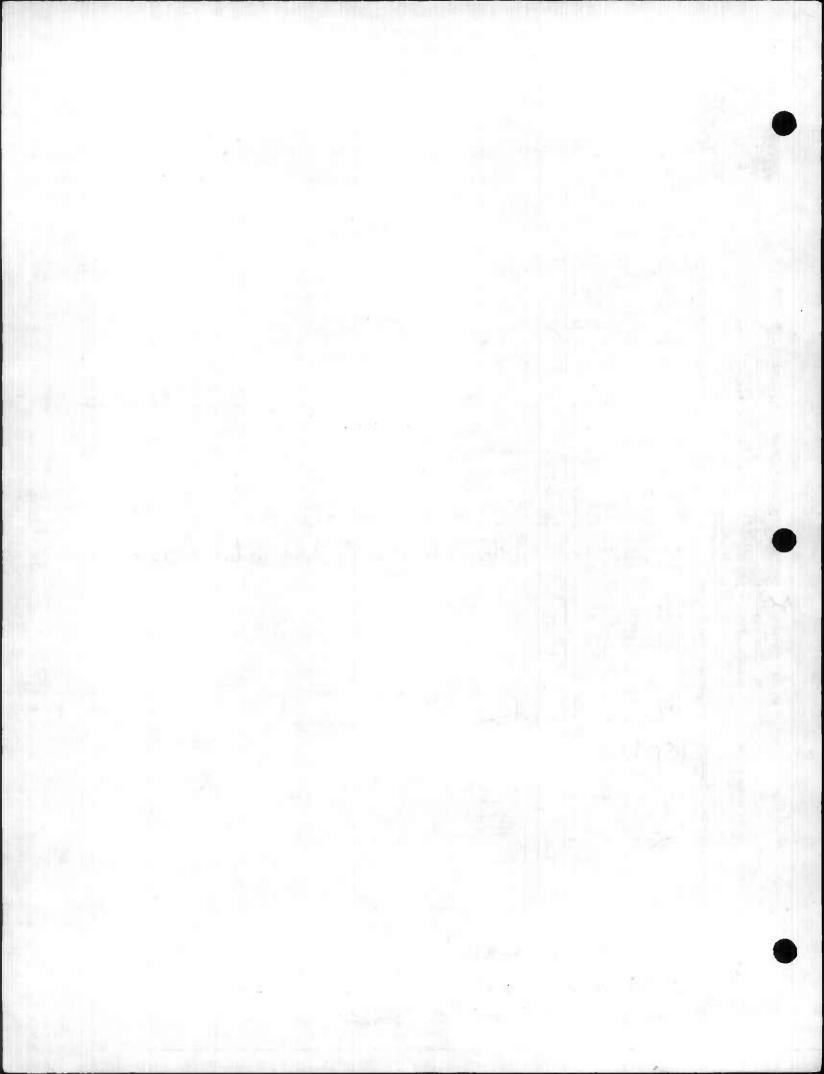
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State of Maryland / Department of Health and Mental Hygiene 99991317

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Physician /Medical	George Thomas	Porcella						LY	Day 4. 199	Year 99	1625 pm
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<b>6</b> - LD	3406 ROSELAWN AVI	ENUE					MORE CI		N/	A	
Funeral Director	5. Social Security Number 6. Sr 214-56-2864 1 Usuat Residence of Decedent	9X 7. Age (In yrs	. last birthday, Yrs.	If Under 1 Months	Yeer Deys	If Under 2 Hours	Min. (Mc	a of Birth onth, Day, 1		Coun	lace (Steta or Foraigr try) yland
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on o ding Ph h. After th funeral	27. Manner of Death  Natural 5 ☐ Pending	28a. Date of tnjury (Month, Day Year)	28b. Tima o Injury	28	. Injun	y at k?	28d. De	scribe hov	v injury occur	rred	
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To the Hospital within 24 hours and To the Funeral completely filled	(Check only 2X) Medical Exam	reician: To the best of my kn iner: On the basis of examin	owledge, deet	h occurred at vestigation, i	tha tin	na, date and pinion, deeth	place, end due	to the cau	use(s) and m	anner as si	lated.
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F. * F. 9	25th. Signature and title of certifier	ortenuo				e number E			d. Date signe	, 199	
8	30. Nem and address of person who co	ompleted cause of death (Ite	m 23a) (Type,	Print)							
	J. CARON LOC	to, MD	111 Pe	enn St	ree	t, Bal	timore,	Man	vland	21201	
State	31. Date filed (Month, Day, Year)	32. Registrer's Sign		,							



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** 28 1999 LORETTA **PUGH** Η. June /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore Franklin S. Social Security Number Square Hos pita Center | cil-e If Under 24 Hrs Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 F 218-26-3862 69 Director 17-1930 Mar. Maryland Usuet Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show Maryland Baltimore Baltimore County Director 1 ☐ Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? than "natural", or llama 23a the Medical Examiner must b 536 Holly Hunt Rd. 21220 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yea 2 ☑ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status Black, Whita, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaking-Own Home 12 yrs. N/A Homemaker 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Meiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental ortant: If from 27 is marked injury or other traumatic av Earl Parkus Harrison Catherine Annabelle Harris 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Samuel E. Pugh 536 Holly Hunt Rd. Baltimore, Md. 21220 Baltimore, 20a. Method of Disposition

\*\*Disposition 3 Removel from State 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 7-1-1999 4 ☐ Donetion 5 ☐ Other (Specify) Holly Hill Cemetery Baltimore, Maryland 22 Name end Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final Encephalopathy disease or condition resulting In death) Examiner Examine iac The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, cation neumonia Physician/Medical Due to (or as a consequence of): signed by the at 1 be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 2 K No certificate 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1□ Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural
2 Accident or Attending 5 Pending investigation 24 hours after deeth. Funeral Director: A 1 Yes 2 No 6 ☐ Could not be 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, term, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29e. Cartifier Medical completely (Check only one) within 2 To the 2 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) Dr. Daniel Shinners 31. Dete filed (Month, Day, Year) 32. 9000 Franklin Square Drive Battimore 32. Registrar's Signature State Registrar

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth 09:45 AM Robert Curtis TULY 1999 03 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Union Memorial Hospital Baltimore If Under 1 Year if Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. 05/10/1929 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 70 Yrs. 9. Birthplece (State or Foreign 100 M 2□ F Months Mary land 212-34-0682 Usuel Residence of Decedent 10a State 10h Count 10c. City. Town or Location 10d. Inside City Limits N/A Baltimore 1 ¥ Yes 2 □ No 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zip Code 4027 DeepWood Road 21218 United States Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work dorie during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Attorney Law 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Raymond Prem Louisa Sachs 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Intorment's Name/Relationship (Type, Print) Mrs. Bernice R. Prem/Wife 4027 DeepWood Road, Baltimore, Maryland 20a. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other pleca) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) Parkwood Cemetery 07/07/99 Baltimore, Maryland Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, Maryland 21214 23e. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediete Cause (Final 3 days Inflammatory Response Syndrome diseese or condition resulting in deeth) Due to (or es e consequence of): Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence ot): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Hepatocellular Carcinoma 24b. Were autopsy tindings aveileble prior to completion of cause of deeth? 24e. Wes an autopsy performed? 1 □ Yes 2 No 1 TYes 25€ No 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Examiner The lew requires that the death certificate be executed physician and the burial-transit Division of Vital Records, P.O. Box 68760, Physician/Medical signed by the a by Completed peen

iis certificate hes t I director, page 2 s

this funeral

After

Director: /

To the Hospital or within 24 hours aft To the Funeral Di completely filled in

Be

2

Certification:

edical

or Attending Physician:

**Physician** 

/Medical

Examiner

Director

Funeral

à

Completed

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**Funeral** 

Director

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Mental hygiene.
Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show my or other transmission of the Marylar or other transmission or the Marylar or other transmission or other transmission.

permit. Page Department of Important: If any injury or once.

**Physician** /Medical

Examiner

Hypertension. Diabetes. End Stage Renal Disease

1 Yes 2 No 27. Menner of Deeth

5 Pending investigation

6 Could not be determined

I Jehad Lakkis, MD

28e. Date of Injury (Month, Dey Year)

28b. Time of

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a, Certifier

1 Naturel

2 Accident 3 Sulcide

4 Homleide

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture end title ot certitier

29c. License number 2438946 29d. Dete signed (Month, Dey, Year) July, 03, 1999

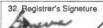
30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print) Jehad Lakkis

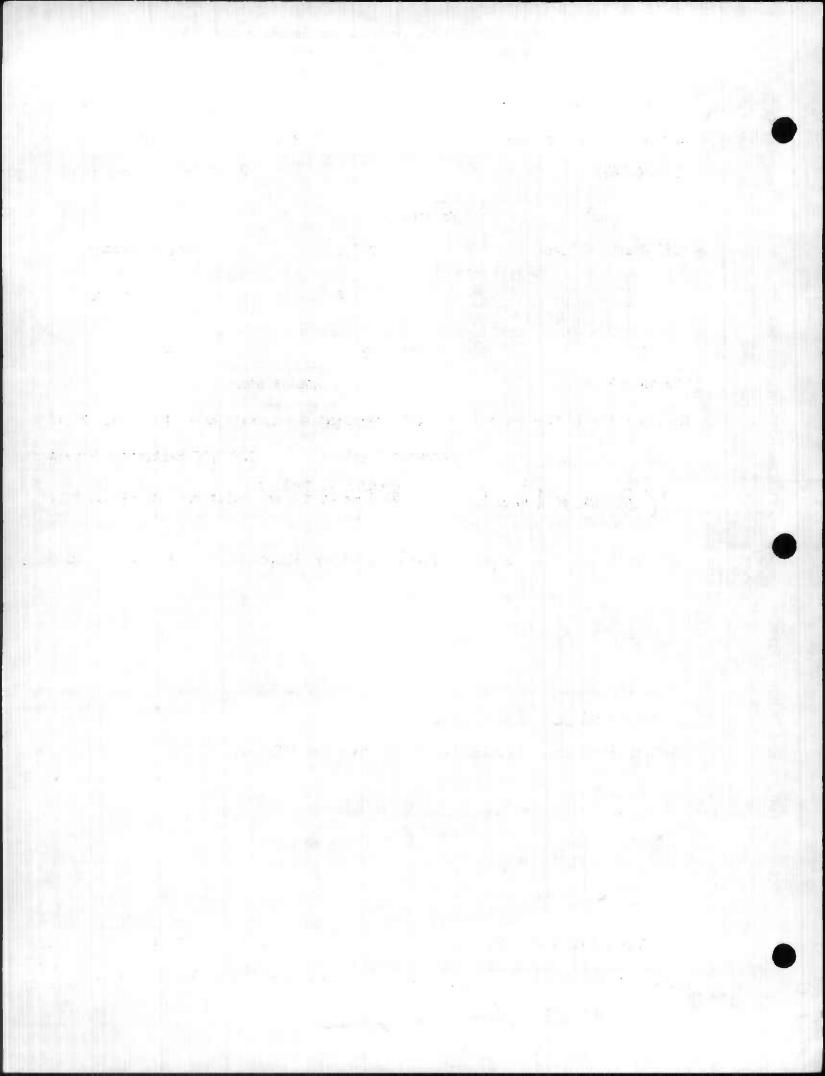
Union Memorial Hosp

201 E Univ Pkway 21218

State Registrar 31. Dete tiled (Month, Dey, Year)

JUL 0 7 1999





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Day Month Year Physician ELI ZABETH PHILLIPS 81.25A1 CORA 1999 05 JULY /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 10 M 20 F 78 oct. 9, 1920 Yrs. 213-12-0725 Maryland Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flarms 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 No Director Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3501 Echodale Avenue 21214 United States Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Datea: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Manager School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) permit. Pages 1 and 2 should be fit Department of Health and Mental H Important: If Itam 27 is marked oth any Injury or other traumstic even Be Emma Jeager 2 George J. Temple 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret A. Dowell (daughter) 34 Mount Rocky Lane Colora, Maryland 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Dete 1 M Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 7/9/99 Parkwood Cemetery Baltimore, Maryland 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Michael E. Canapp 5305 Harford Road ana/1/2 Baltimore, MD 21214 LEONARD J. RUCK, INC. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one ceuse on each line. Approximete Interval Between Onset end Deeth **Physician** '/Medical Immediate Cause (Finel Sepsis disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner 217,4 cm0349 be executed attending physician and for use as the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 1 Yes 25 No 3 Probably 4 Unknown signed t by 24b. Were autopsy findings available prior to Completed 24a. Wes en autopsy performed? completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Be 25. Was casa referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury st Work?

P.O. Box 68760. Division of Vital Records. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

5 Pending investigation **⊘**Netural 1 Yes 2 No 2 Accident 6 Could not be 3 Sulcide 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 281. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier 🖒 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end menner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the ceuse(s) end manner stated.

29b. Signature end title of certifier-29c. License number 29d. Date signed (Month, Day, Year)

20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BLUD. ANGM SABRA 601 BACIINORE UD 51538 WOCH PAVEN

P 11390

JULY 05, 1999

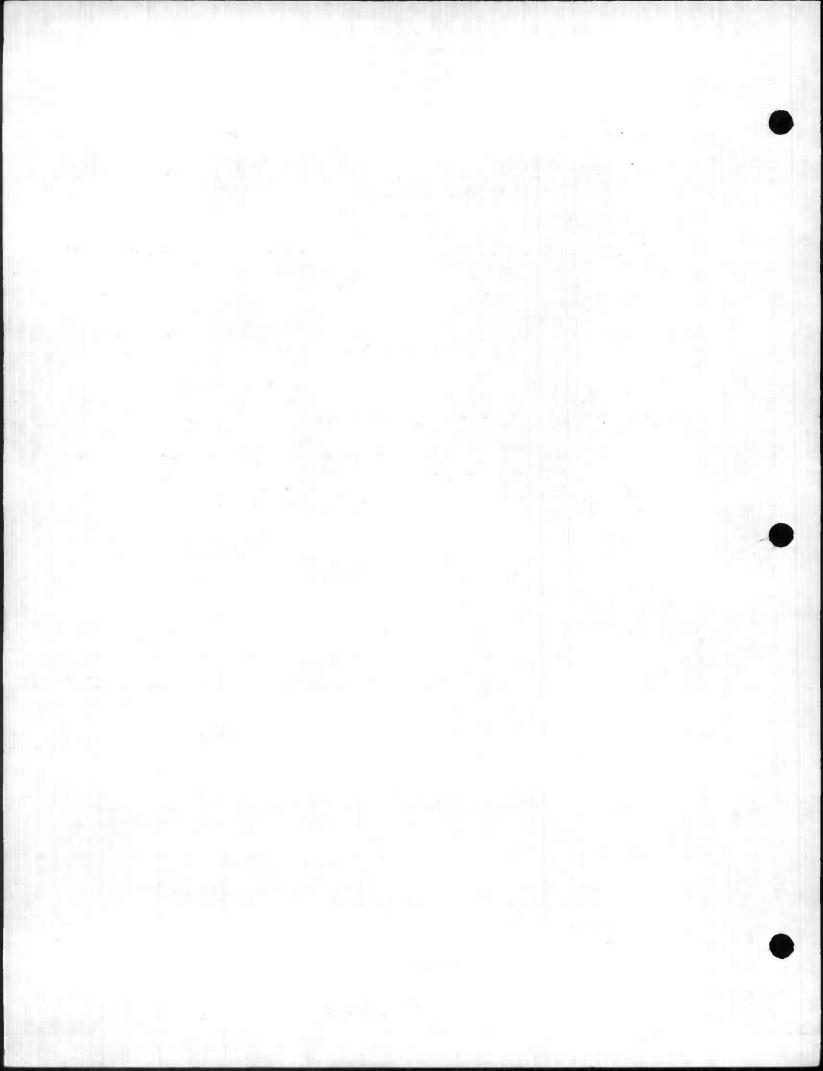
Registrar

Medical

31. Dete filed (Month, Dey, Year) JUL 0 7 1999

4 Homicide

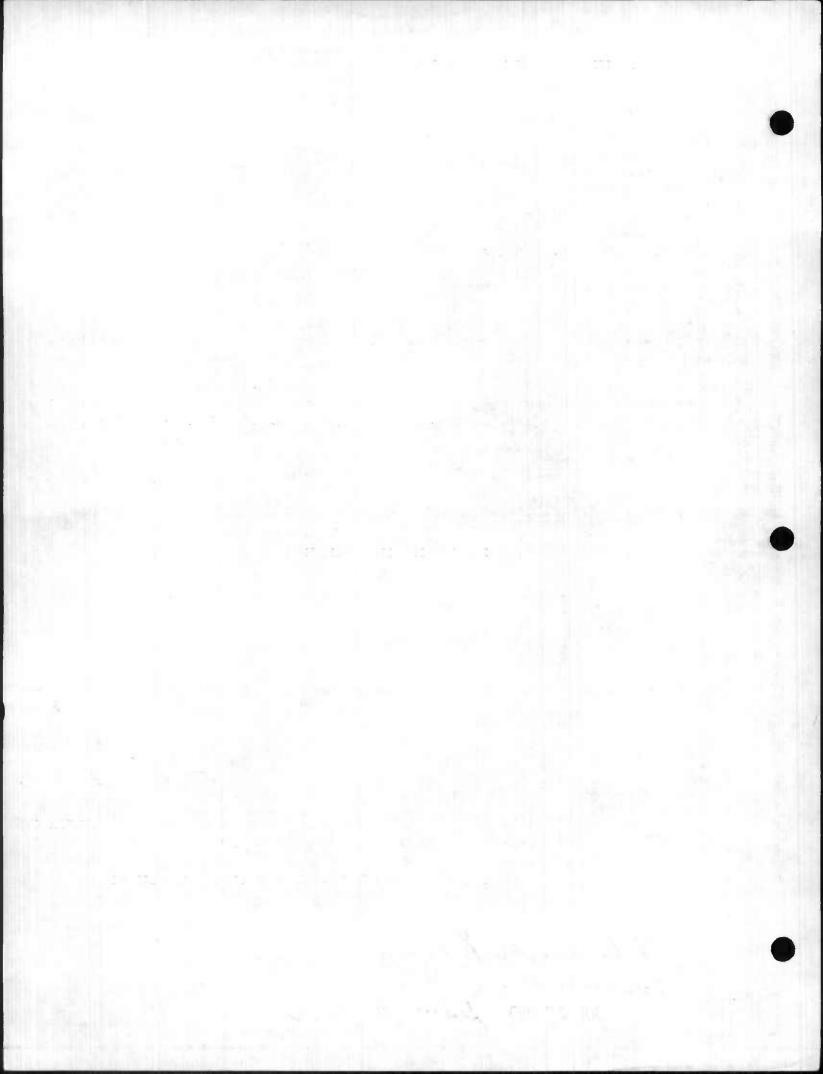
32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Name (First, Middle, Last,	PART I, 27, 28A-			2. Dete of De Month	ath	Year 3. Time	of Death
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xaminer	4a Facility Name (If not Institution, give		)		r Location of Death	4c. County		
	MARYLAND GENERAL			BALTI			119	
neral ector	216-31 1263	7. Age (In yrs. I	Yrs. If Und	er 1 Year If Under 24 H s Days Hours Mi		th y. Year) 16, 1995	9. Birthplace (State Country)  May 4/8	or Foreign
	Usual Residence of Decedent  10a. Stete 10b. County	/ 10c. City	, Town or Location				10d. Inside (	City Limits
ral Director	Harylow 1	A	BALTIM	ore			-100	2 No
Le lie	10a. Street and Number	į	# F 101. 2	ip Code		10g. Citizen of W	/hat Country?	
or runt b	843 LENNOX	STREET		21217		15	29	
by Funeral Director	11. Meritel Status  12 Never Married 2 ☐ Merried  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U, Armed Forces? 1 ☐ Yes 2200 If Yes, Give Year or Dates:	S. 13. Was Dec	edent of Hispanic Origin? ecify Cuban, Mexican, Pur 2200 Specify:	(Specify Yes or No arto Rican, etc.)	Blec	e-American Indian, k, White, etc.	
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	19e. Informent's Neme/Relationship (Ty			ss (Street and Number or	Rural Route Numb	er, City or Town,	Stete, Zip Code) 2/	215
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an al e	tmmediete Cause (Final disease or condition resulting in death)	ABDOMINAL INJU	URIES WITH CO				Onset end	Deem
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						an autopsy med?	24b. Were autopsy available prior completion of of death?	to
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Completed	25. Was case referred to medical			26. Place of D	eeth (Check only		1 100 2	J No
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DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death July 6, 1999 **Physician** Steven Anthony Rasheff 5:00 A.M. /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Glen Burnie A

If Under 24 Hrs. 8. Date of Birth
Hours Min. Dec. (Month 9 Jay, 19918 Mariner Health Anne Arundel If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1₽M 2□F 351-09-3395 80 Il finois Yes **Director** Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f ahow than "natural", or hams 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 341 Chalet Drive 21108 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural". or heapy Injury or other traument. 1 V Yes 2 No WW II If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Maryland 21215-0020 1 ☐ Yes 2 ☐No Specify: Specify: White À 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chef Railroad 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 36 Steven Rasheff Anna BRENC 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Behringer/Daughter 341 Chalet Drive Millersville, Md 21108 altimore, 20b. Plece of Disposition (Name of cemetery, crematory or other place) JULY 7, 20e Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stele Metro Crematory Catonsville, MD 1999 4 Donation 5 Other (Specify) 21. Signature of Funetal Service/Licensee 22. Name and Address of Fecility Kirkley-RUddick Funeral Home P.A. 421 Crain hwy. S.E. Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervei Between Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical RESPIRATORY FAILURE HOURS Examiner Physician/Medical Examiner EREBRO MASCULAR ACCIDENT MAXS I or Attending Physician: The law requires that the death certificats be executed after death.

Director: After this certificate has been signed by the attending physician and cin by the function and cin by the function page 2 should be deteched for use as the burst-transit air has the signed by the function. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last ATHEROSCLEROTIC CEREBIZO VASCULAR DUENTE YEARS Box 68760 Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yaa 2 No 3 Probably 4 Unknown DIABETIES MELLITUS TYPE 2 PEPTIC ULCER Division of Vital Records, Completed by 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes en eutopsy performed? DISEASE, ANEMIA, DEPOZESSION, HYPERTENSION. NEPHROTIC SYNDROME. MALNUTRITION 1 Yes 2€No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturei 5 Pending 1 Yes 2 No investigetion 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, term, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 1XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

State Registrar

**DHMH 16 Rev 6/95** 

071999

Ruben Reider,

31. Dete filed (Month, Day, Year)

19

32. Registrar's Signature

agragay

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

M.D.

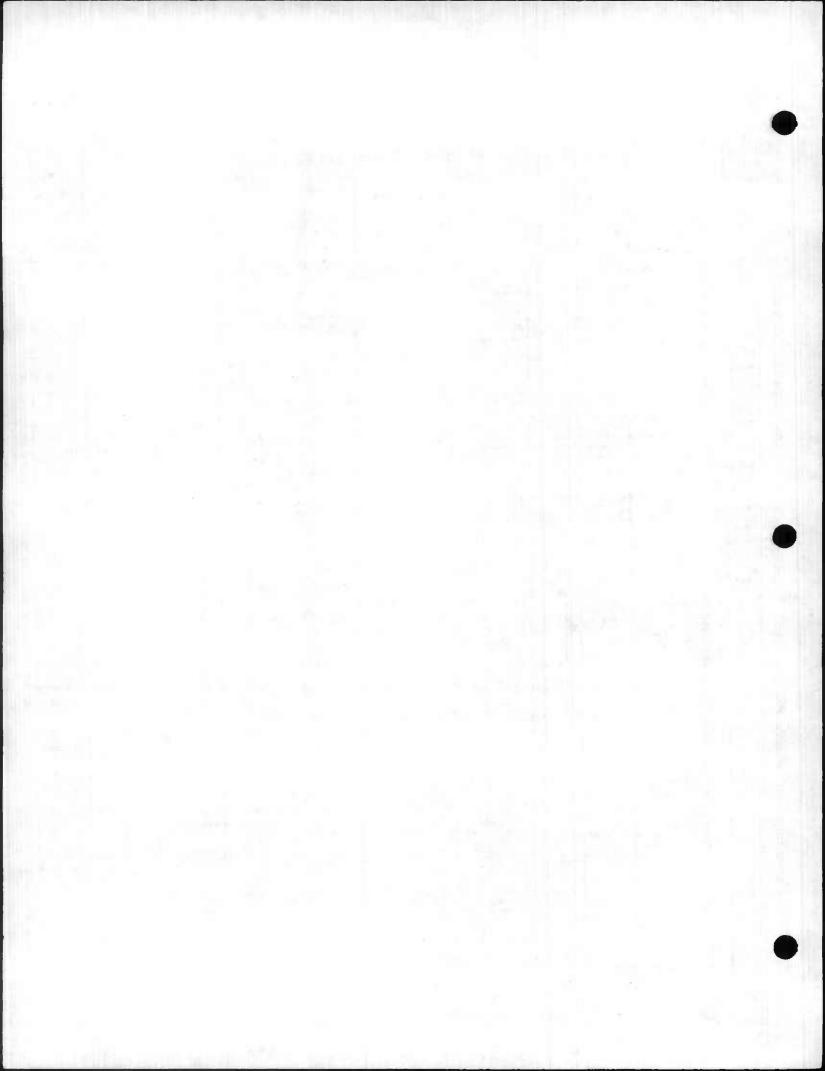
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Sparke

D0054288

7445 Furnace Branch Rd. Glen Burnie, MD 21061

July 6, 1999



in		FR F.H. G77 ecedent's Name (Fir					rtificate of		2. Date of De	Reg. No.	Year	3. Time of Deal	
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by Funeral	i	Reritel Status  Never Merried  Widowed 4		12. Was Dec Armed F 1  Yes If Yes, G Year or	cedent Ever in Corces? 2 No ive		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No	lispanic Origin? (S an, Mexican, Puer Specify:	specify Yes or No to Rican, etc.)	Specify	ce - America ck, White, o		
			Decedent's to highest g			16a. Decedent's Usual Occupation (Give kind of work done during most of work) life. DO NOT use retired)			rking	16b. Kind of Busi		iness/Industry	
fits event, the Medical.  To Be Completed	Ek	ementary/Secondary	y (0-12)	College	(1-4or 5+)		ORER	-/		TEMPS	7 701	ZNIOW.	
	17. F	ather's Name (First,	, Middle, Las	st)		LAD	OKEK	18. Mother's Nar	ne (First, Middle	, Maiden Suman		SNCI	
ToB	J	DSEPH WA	ARREN					MERIE	WARREN				
-	19a.	Informant's Name/F	Relationship	(Type, Print)	12	19b. Meili	ing Address (Street			er, City or Town,	State, Zip	Code)	
	R	OSLYN WA	ARREN				3 GREGO	RWAY, B	ALTO.	MD, 212	224		
		Method of Disposition		□ Bemovel from		Place of Dispo cemetery, cre-	osition (Name of metory or other ple	ce)	Date	20c. Location -	City or To	wn, State	
		Donation 5				UNT Z	ION		7-8-99	LANDSI	OOWN	MD	
	21. Signature of Furieral Service Licanus HOWELL FUNERAL HOME												
		Ville	, 8	Humily	y		4600 LI			JE. BAT	.то	MD 212	
	23a.	Part1. Enter the dis	sease, or con ure. List onl	mplications that y one cause on	caused the dea	th. Do not en	ter the mode of dyir	ng, such as cardia	c or respiretory a	rrest,		Approximeta Intervat Between	
												Onset and Deet	
	dise	ediate Cause (Final ese or condition Iting in death)		a.PNEU	MONIA							4 DAYS	
- er						or es a conse							
Examiner	b.HEPATIC ENCEPHALOPATHY								1	4 DAYS			
Exa	if an	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.											
dicai	mat	Initiated events		C	Due to (	or as a consec	quence of):						
73		ting in death) Last									i		
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		l. Other significant	conditions	contributing to c	leath but not re	sulting in the u	ınderiying cause giv	ren in Pert I.	23b. Did	tobacco use co	ntribute to	the cause of de	
Physician/Me	Pert I					sulting in the u	inderlying cause giv	ren in Pert I.		tobacco use co Yes 2 XNo			
by Physician/Me	Pert I	I. Other significant				sulting in the u	inderlying cause giv	ren in Pert I.	10	Yes 2 XNo	3 □ Prot	pebly 4 Unk	
by Physician/Me	Pert I					sulting in the u	inderlying cause giv	en in Pert I.	1 - 24a. Wes	-37	3 ☐ Prot	pebly 4 Unk	
by Physician/Me	Pert I	LCOHOLIC NEMIA	PAN	CREATI		sulting in the u	inderlying cause give	en in Pert I.	1 🗆 24a. Wes	Yes 2 No an autopsy ormed?	3 Prot	pebly 4 Unk are autopsy findinaliable prior to inpletion of cause death?	
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edical Certification: To Be Completed by Physician/Me	A1 A1 A2	LCOHOLIC NEMIA  CUTE REN Vas case referred to xaminer? Yes 2 No lanner of Death Natural 5   Accident   Suicide 6   Homicide	Pending Investigation determined	AILURE Hospital: 128a. Date (Moi	Inpatient 2C of fnjury th, Dey Year) e of fnjury - At tiling, etc. (Spec	28b. Time of Injury  lome, farm, strify)	nt 3 DOA Oth    28c. Injury   Word   M	26. Place of Deler: 4 Nursing Hyat k? Yes 2 No	24a. Wesperful  24a. Wesperful  1 □  ath (Check only)  tome 5 □ Resi  28d. Describe  28f. Location (City or To	Yes 2 No an autopsy ormed?  Yes 2 No one) dence 6 Oth how injury occur  Street and Numb wn, Stete)  cause(s) and me date and place,	3 Protein Specify Protein Spec	pebly 4 Unku	
edical Certification: To Be Completed by Physician/Me	A] A] A] A] A(25. V 6. V 1. 1 2. 3 3 4 4	LCOHOLIC NEMIA  CUTE REN Vas case referred to xaminer? Yes 2 No lanner of Death Natural 5   Accident   Suicide 6   Homicide	Pending Investigation Could not determined	AILURE Hospital: 128a. Date (Moi	Inpatient 2E of fnjury ath, Dey Year)  e of fnjury - At hing, etc. (Spec	28b. Time of Injury  lome, farm, strify)	nt 3 DOA Oth  28c. Injur  Wor  M 1 creet, factory, office	26. Place of Deler: 4 Nursing Hyat k? Yes 2 No	24a. Wesperful  24a. Wesperful  1 □  ath (Check only)  tome 5 □ Resi  28d. Describe  28f. Location (City or To	Yes 2 No an autopsy primed?  Yes 2 No one) dence 6 Oth how injury occur  Street and Numb wn, Stete)	3 Protein Specify Protein Spec	pebly 4 Unker under autopsy finding aliable prior to impletion of cause death?  Yes 2 No  What Route Number, aliable the cause(s)	
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### Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Deeth 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death BonSecour Hospital Baltimore If Under 1 Year if Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, You 11-20- Birthplace (State or Foreign Country) N C 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) Hours 1□ M 2□ F Months Daya 74 577-44-0418 Yrs. Usuei Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inalde City Limits MD NA 1€ Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1504 W. Fayette Street 21223 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married Specify: Black 1 Yes 2 XNo Specify: 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) High Sch Grad. College (1-4or 5+) NA Presser Laundry Co. 18. Mother's Neme (First, Middle, Malden Surneme) 17. Father's Name (First, Middle, Last) Lester Monds Bessie Wilson 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) James V. Smith 1504 W. Fayette Street Baltimore, MD. 21223 20b. Placa of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State CHurial 2 ☐ Cremation 3 ☐ Removel from State 07-05-99 Rest Haven Cemetery Dunn, N.C. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licanses 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue BIL 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lest disease 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to geath but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 □ Unknown 24b. Were autopsy findings available prior to 24a. Wes an autopsy completion of cause of deeth? Yes 2 No 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 npatient 27. Menner of Deeth 28c. Injury at Work? 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural 2 🗆 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Examiner the death certificate be executed and burial-trar physician the 50 USB ō the

Examiner Physician/Medical þ Completed Be funeral Certification:

**Physician** /Medical

**Examiner** 

Director

Funeral

þ

Completed

**Funeral** 

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic avent, the Mod cal Examiner must be notified at

other

injury or

**Physician** /Medical

eny is

permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23.

Saltimore, Maryland 21215-0020

the Manyland

signed by t Division of Vital or Attending Physician: this After death. after death 24 hours a Hospital To the I within 2

Registrar

State

Medicai

29a. Certifier

29b. Signature and effect certific

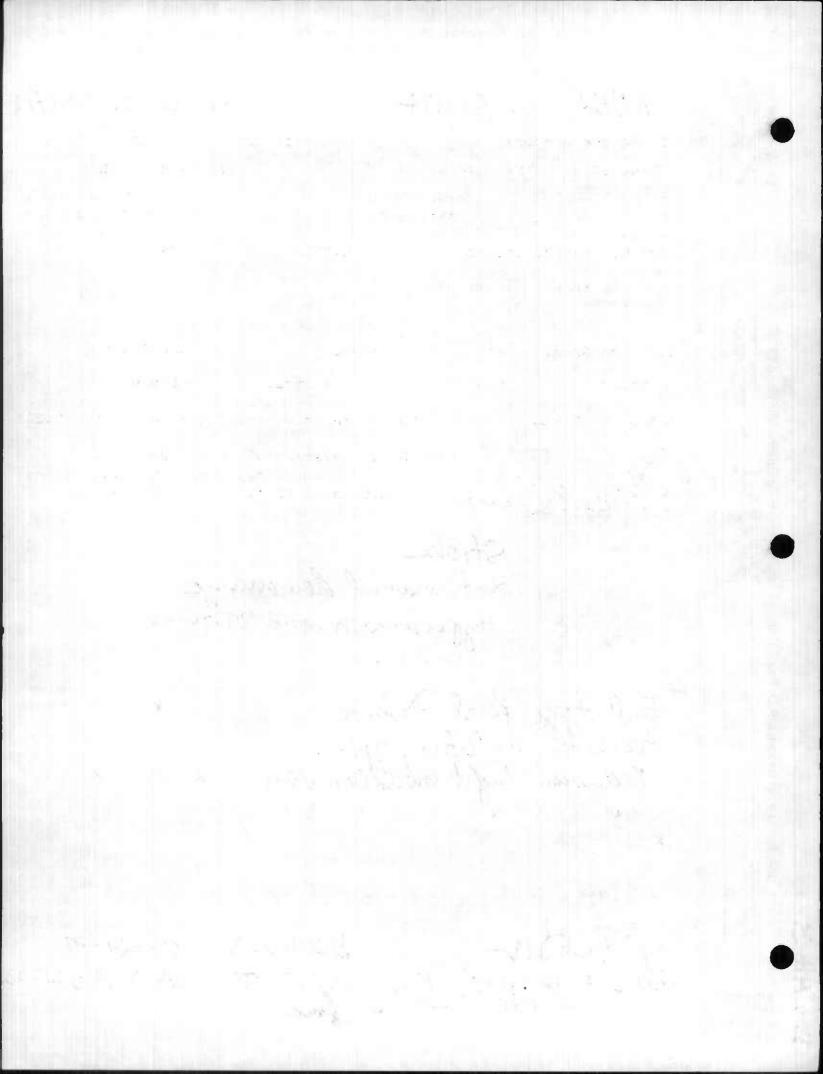
and manner stated.

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Dey, Year)

completed cause of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month ALMETA C. SIMMONS
4e. Fecility Neme (If not institution, give street end number) SIMMONS 07. 04-/Medicai 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner SOUTH PIKESVILLE ROAD 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) **Funeral** 10M 20 F Deys Hours 436-32-9546 Yrs. Director Usual Residence of Decedent 10e. Stete 10h Count 10c. City. Town or Location ns 23s or 28s-f show 10d. Inside City Limits 1 Yes 2 NO Funeral Director rleans 10e. Street end Number 10g. Citizen of Whet Country? 4761 FLAKE AUENUE 70127 USA 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Detes: 11. Meritel Status 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. traumatic event, the Medical Examiner filed within 72 hours aftar 1 Never Merried 2 Married 1 Yes 2 No Specify: 21215-0020 6 Specify: BLACK þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) I Hygiena. Elementery/Secondary (0-12) Colleger (1-4or 5+) OMESTIC 2 ND GRADE HOME NIA and Mental Hygie Is marked other Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be OPHUA 2 UNKNOWN Unk 19e. Informent's Name/Relationship (Type, 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health a Important: If Itam 27 Is any Injury or other trains HARGROVE SOUTH YIKESVILLE, MD. DAUGHTER Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition
1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 20c. Location - City or Town, Stete METRO CREMATORY 7-8-99 BALTO. MO 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility
VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO, NATL' PIKE, BALTO. 23e. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory errest shock, or heart(feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Preumonia /Medical Immediete Ceuse (Final diseese or condition resulting in deeth) Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last The law requires that the death certificate be axecu thero sclerotic P.O. Box 68760, Physician/Medicai Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 2 PNo After this certificata 1 Yes 2 No Division of Vital To the Hospital or Attanding Physician: within 24 hours after death.

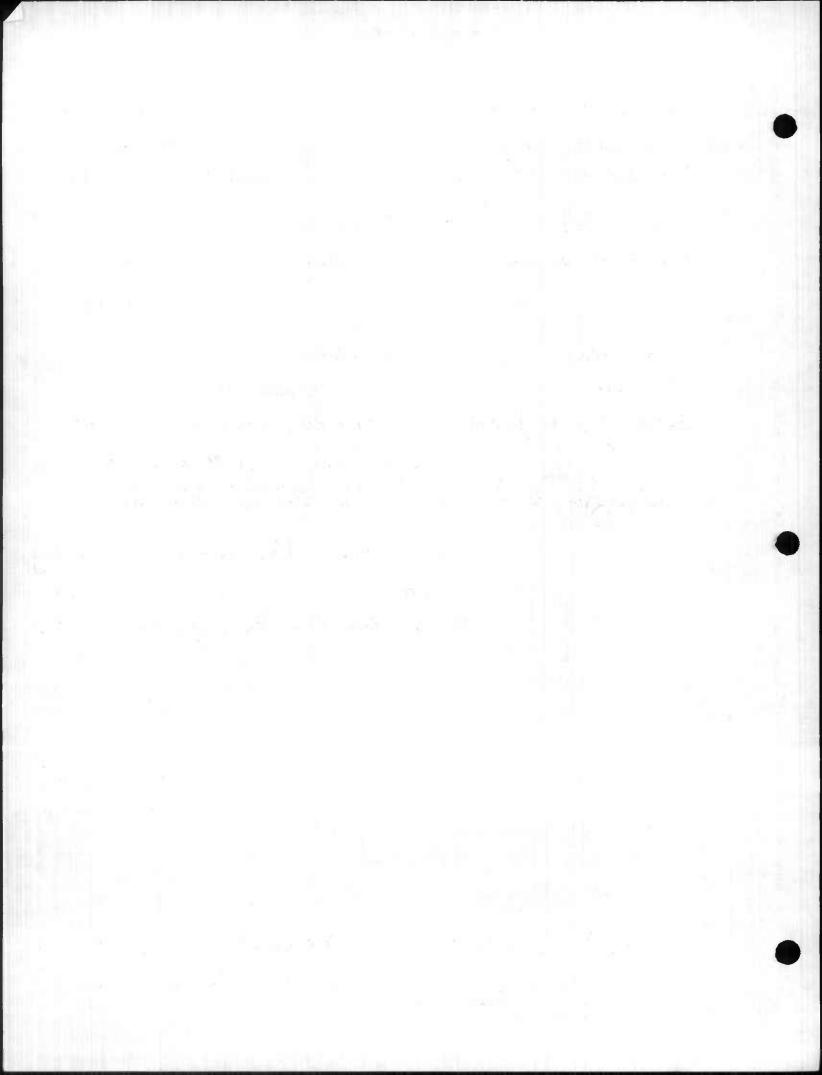
To the Funeral Director: After this certifica completaly filled in by the funeral director; p. Be 25. Wes cese referred to-medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 2 1 Yes 2 No 5 Residence 6 Bother (Specify) Sen's House 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and menner stated. Medical 29e. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) amara, M.D. Cylvest St. # 520, Baltimore, Mo 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

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Samara 1837 N 1000 32/Fegistratus Gnature

State Registrar

Waiel 31. Dete filed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nema (First, Middle, Last) 2. Data of Daath 3. Tima of Death Month **Physician** JULY, 5, 1999 0901 MARY SEWARD /Medical 4b. City, Town, or Location of Death 4a Facility Nema (If not institution, give street end number) 4c. County of Death Examiner BALTIMORE if Under 24 Hrs. ST AGNES HOSPITAL BALTO. CITY If Undar 1 Yaar 5. Social Sacurity Number Birthpiaca (Stata or Foraign Country) 6. Sex 7. Age (In vrs. lest birthday) 8. Data of Birth (Month, Day, Yaar) **Funeral** Months Days Hours Min. 1 □ M 2 💢 F Yrs. Director 218-26-8098 68 4-11-1931 N.C Usuei Rasidence of Decedent the Marylend 10a Steta 10b. County 10c. City. Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28s-f sho traumstic avent, the Medical Examiner must be notified as 1 ☐ Yas 2(1) No Director MD BALTO, CO. CATONSVILLE 10f. Zip Coda 10e. Street and Number 10g. Citizen of What Country? with 82 WINTERS LANE 21228 death y Funeral 12. Was Decedant Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, White, atc. permit. Peges 1 end 2 should be filed within 72 hours effer to Department of Health end Mentel Hyglene. Important: If Itam 27 is marked other than "natural", or Net any Injury or other traumetic avent, the Medical Exertines. 1 Yas 2 No If Yas, Give Yaar or Datas: 1 Navar Marriad Married Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: SpecifAFR. AMERICAN þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usuat Occupation (Giva kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Elemantary/Secondary (0-12) College (1-4or 5+) nurse's aid medical field 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middle, Maidan Sumame) Be MARTIN WATFORD MARY MOORE 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) VERNON SEWARD 82 WINTERS LANE CATONSVILLE MD 21228 altimore, 20b. Place of Disposition (Nama of cematary, cramatory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 Donation 5 Other (Specify) -10-1999 BROTHERS FUNERAL WESTERN CEMETERY 7-21. Signature of Fuseral Service Vicensee 22. Neme and Addrass of Facility 1300EUTAW PLACE BALTIMORE MD 21217 201 e, or complications that caused the List only one cause on each line. Approximata Intervei Between Onsat and Death not enter tha mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical immediate Ceuse (Final diseasa or condition rasulting in deeth) Examiner Dua to (or all a consequenca of): Examiner cons physician and the buriel-tran Sequentially fist conditions, if any, laading to immadiata causa. Enter Undarlying Causa (Disaasa or injury that initiated evants rasulting in death) Last Due to (or es a consequença of): law requires that the death certificate be Physician/Medical Dua to (or as a consequanca of): 88 USB 23b. Did tobecco use contributs to the cause of deeth? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate hes been signed by page 2 should be detact 1 Yss 2 No 3 Probably 4 ₩ thknown þ 24b. Were eutopsy tindings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? 2 No 1 □ Yas 1 □ Yas 2 □ No After this certificate MARY V Be 25. Was casa refarred to medical 26. Place of Daath (Chack only ona) Hospital: 1 ☐ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Rasidenca 6 Other (Specify) P 1 Yes 2 →NO 28a. Date of Injury (Month, Dey Year) 28c. injury et Work? 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred Certification: 5 Panding 1 Divatura 1 Yas investigation 2 Accidant efter deet Director: 3 Suicida 6 Could not be determined 281. Location (Streat and Number or Rurel Route Number, City or Town, Stete) Place of Injury - At home, farm, street, factory, offica building, atc. (Spacify) 4 Homicida 24 hours 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edicai 29e. Certifier and mannar stated. To the Within 2 29c. Licansa number 29d. Data signad (Month, Day, Year) 29b. Signatura and litia of cartifiar 050708

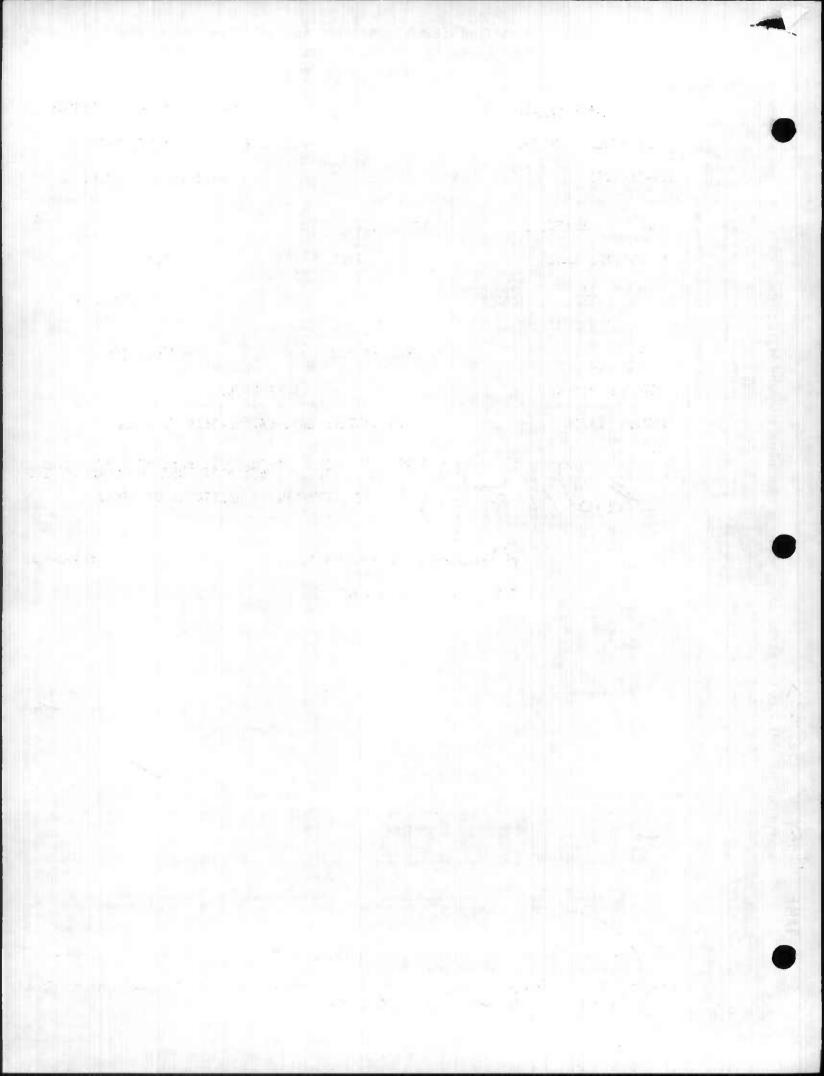
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On 30. Nama and addrass of person who completed causa of death (item 23e) (Type, Print)

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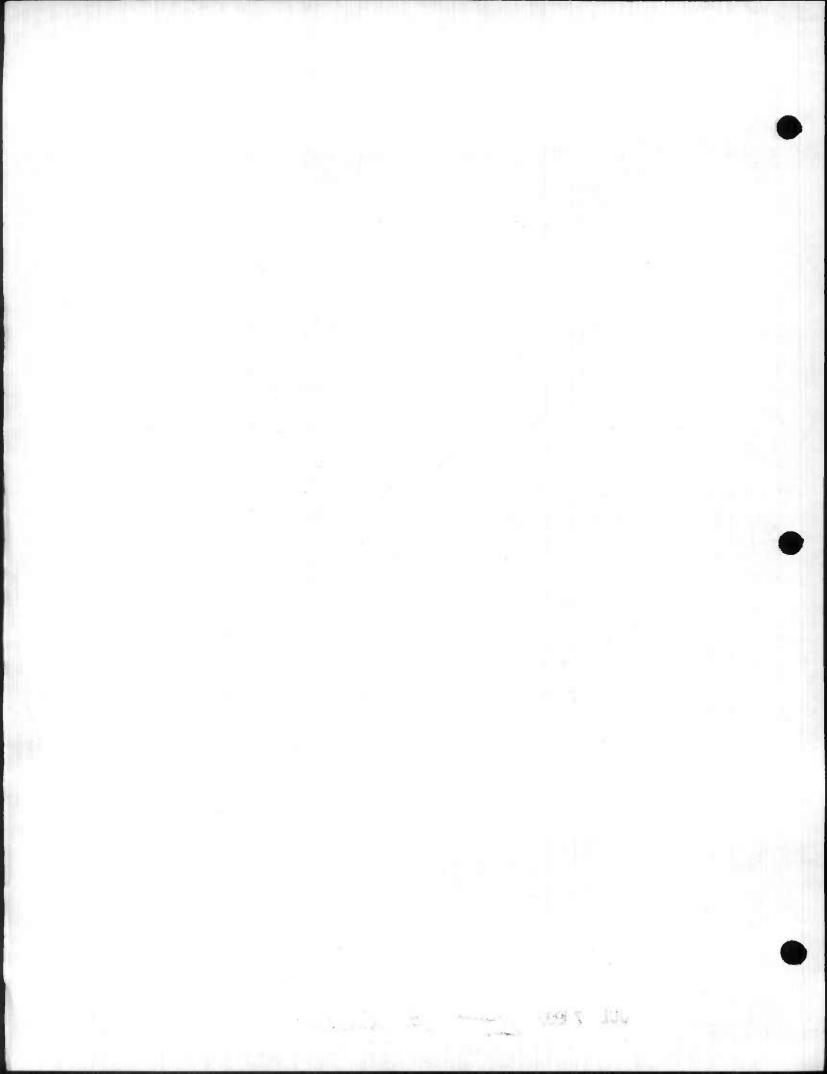
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one) 1 Certifying Physical Examination	ner: On the besis of	of my knowledge, dee	eth occurred et the investigation, in my	time, date and piece opinion, deeth occu	, end due to the rred at the time	ceuse(s) end m	enner es st end due to	eted. the cause(s)
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State Registrar

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32. Registrer's Signetur

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#### Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Month DayTH SMITH CARORGE JULY 06 1:00Am 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death RANDALLSTOWN CENTER BALTIMORE, HOSPITAL NORTHWEST 7. Aga (In yrs. last birthday) If Under 1 Year If Undar 24 Hrs. 8. Data of Birth Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (Stata or Foraign Country) Months Days 1 X M 2 □ F Yrs Dec 24, 1917 218-05-1433 Maryland Usual Rasidence of Deceden 10a State 10h County 10c. City. Town or Location 10d. Insida City Limits 1 Yes 2 □ No MD n/a Baltimore 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? Apt. 315 3801 Schnaper Drive 21233 USA 12. Was Decedant Evar In U,S. Armed Forcas? 1 □XYas 2 □ No 13. Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Naver Marriad 2 Married 1 Yas 2 No Specify: Specify: Year or Datas: WWII 3 DWidowed 4 □ Divorced Black 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Spacify only highast grada completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Coilega (1-4or 5+) 12th Grade Information Clerk B & O Railroad 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Jacob Oscar Smith Katie L. Smith 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19e. Informent's Name/Reletionship (Type, Print) SOD Baltimore, 505 Random Road MD 21229 George B. Smith 20a. Mathod of Disposition 20b. Placa of Disposition (Nama of cematery, cramatory or other placa) Data 20c. Location - City or Town, Stata 1 X Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 ☐ Other (Specify) altimore Nat'l Cemetery Baltimore MD 22. Nama and Addrass of Facility Nutter Funeral Homes, Inc. 21. Signatu Funeral Service Licer 2501 Gwynns Falls Pkwy Baltimore, MD 21216 En Part L Entar tha diseasa, or con plications that caused shock, or haart failura. List only ona causa on aach li death. Do not antar tha moda of dying, such as cardlec or respiratory arrast, Approximate Interval Batween Onset and Death Immediata Causa (Final MENWONIY. disaasa or conditio rasulting in daath) Dua to (or as a consequanca of) Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disaasa or injury that initiated avents resulting in deeth) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ACCIDENT CEREBROURSCULAR 24b. Wara autopsy findings available prior to completion of cause of deeth? 24e. Wes en eutopsy MELLITUS. DIABETES HUPERTERSION 1 Yes 2 No 1 Yas 2 No 25. Was casa rafarrad to medical axaminar? 26. Placa of Daath (Check only one) Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Hospitai: 1 Npatiant 2 ER/Outpatient 3 DOA 1 Yes 2 No 28a. Data of Injury (Month, Dey Year) 27. Manner of Death 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be datermined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Pleca of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida

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**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Baltimore, Maryland 21215-0020

Director

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31. Data filed (Month, Day, Year) JUL 0 7 1999

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30. Name and address of person who completed causa of daath (Itam 23a) (Type, Print) HARISH. 32. Redistrar's Signatura

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12 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and due to tha causa(s) and mannar as steted

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the causa(s) and manner stated.

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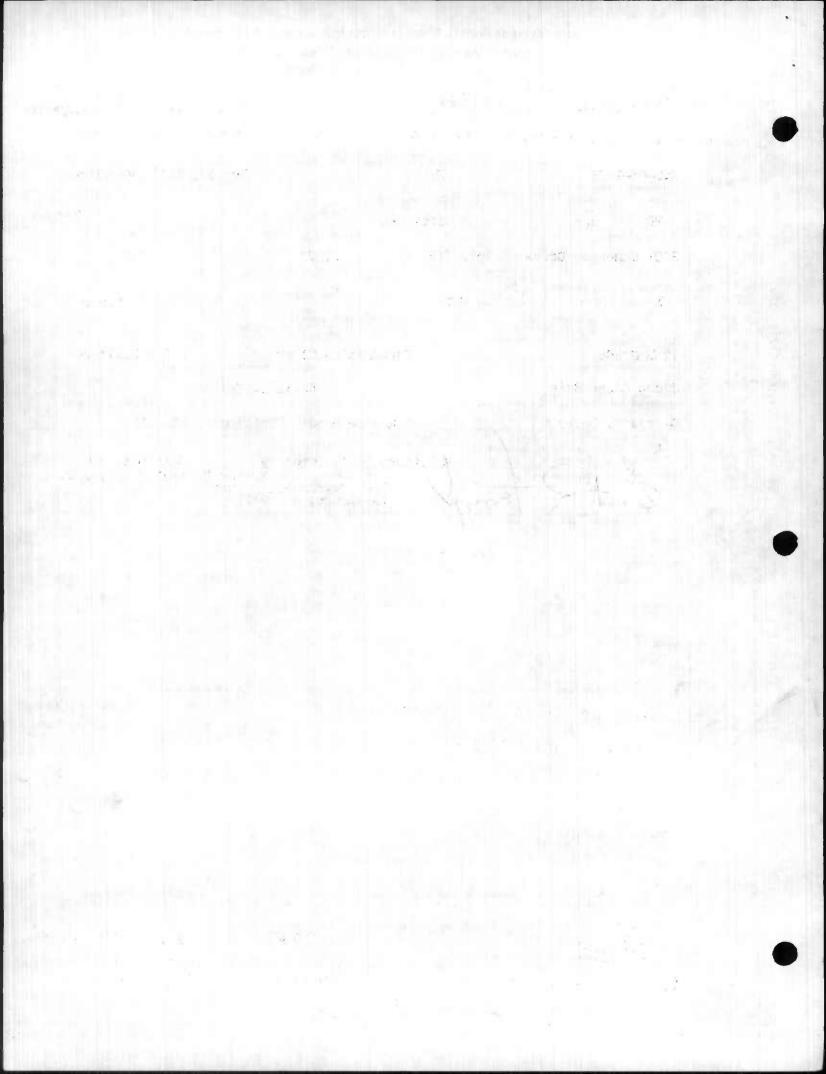
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FOXFORD STREAM



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Day **Physician** 7:40 M hE Louise /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Latayette Ave Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 216-09-1□ M 28 F Yrs. Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ahow Baltimore at 1 Yas 2 No 2861 **Funeral Director** 10g. Citizen of What Country? 10a. Street and Number 2861 4.8.A 14. Race - American Indian, Black, White, etc. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status I ☐ Yes 2 No If Yes, Give Specity: Atricon - American hours after 1 Never Merried 2 Merried 1 Yes 2 No Specify: à 3 Notice 3 Divorced Year or Detes: Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) LamTress Privale 10 Department of Health and Mental Hygis Important: if Item 27 Is marked other is any Injury or other traumatic event, is 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental ouise 0 Williams 19e. Informant's Neme/Reletionship (Type, Print) (Daughter) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hatricia 272 Batto. Md KP 20b. Plece of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Surial 2 Cremetion 3 R 4 Donetion 5 Other (Specify) cemetery, cremetory or other piece) 3 Removal from Steta OWINGSI 21. Signature Funerel Service Licens 216 rin Pan A. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, and ck, or heart feiture. List only one cause on each line. Approximate Interval Between Onsat and Deeth **Physician** /Medical Immediate Cause (Final Tailure disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be exec Physician/Medical 4 Due to (or as a consequence of) 88 987 be detached for Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 1 No 3 Probably 4 Unknown Š 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Be Completed 2 No 1 ☐ Yes 2 ☑ No certificate 1 Yes or Attending Physician: 25. Wes case referred to medical examiner? 1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? After 5 Pending investigation 1 Naturel death. 1 ☐ Yes 2 □ No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29a. Certifier (Check only one) To the 29d. Data signed (Month, Day, Year) 29b. Signature and sale of certifier 29c. License number

State Registrar

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Box 68760.

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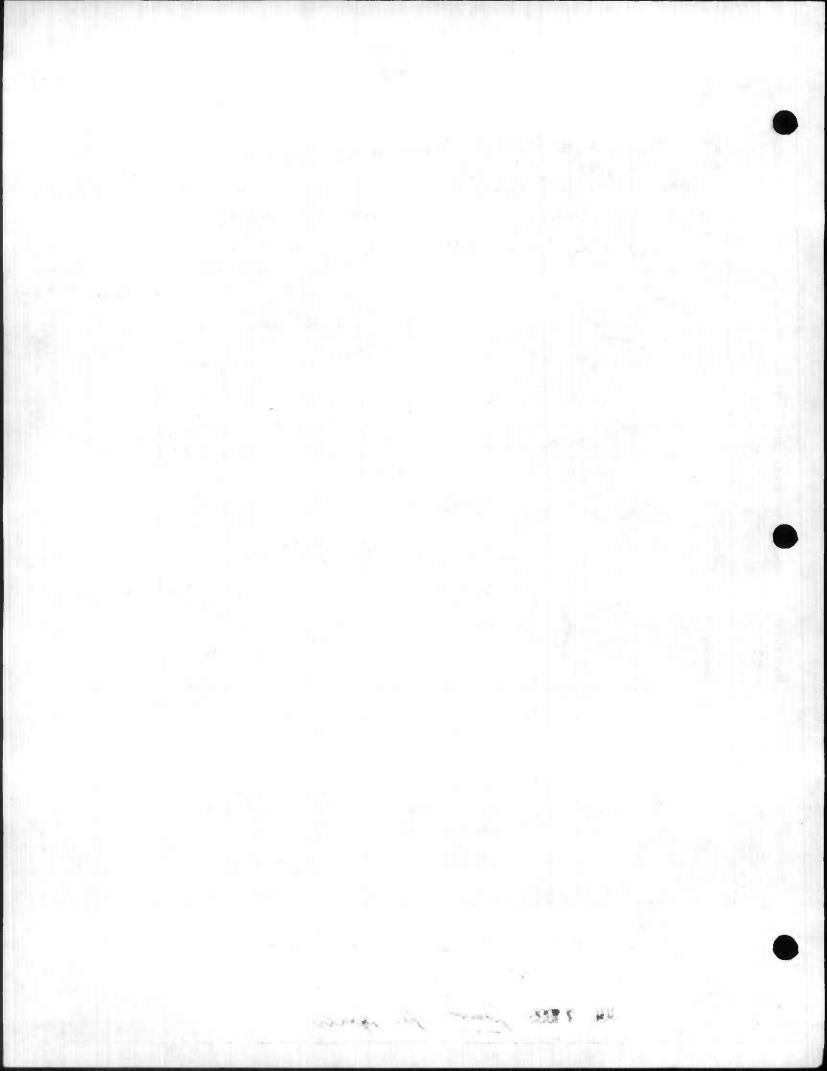
nd address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ignature G. Spark

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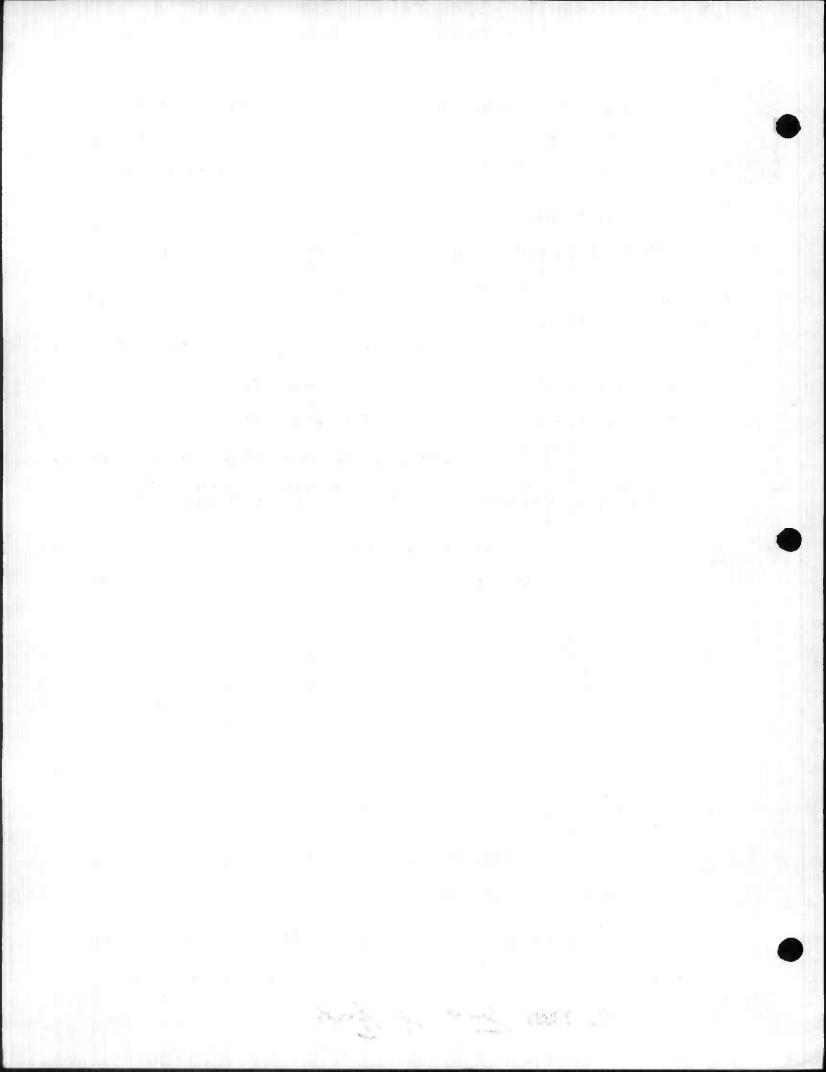
**ORIGINAL** 



State of Maryland / Department of Health and Mental Hygiene

						Ce	rtificate	of Death		Reg. No.	_	
	-		1. Decedant's Nama (First, Middle, L	.ast)					2. Data of De Month		Veer	3. Tima of Death
п	Physic /Medi		MARY MARGARET	BROCKMA	N SK	IPPER	2		JULY	02 199	99	3:10am
	Exami		4a. Facility Nama (If not institution, g	iva street and numbe	r)			4b. City, Town, o	Location of Deat	h 4c. County	y of Death	
			FRANKLIN WOOD	BALTIM	ORE	BAL	TIMOR	E				
	Funeral Director		412-16-9384	Sax 7. A 1□M 2⊠F	nga (In yrs. 78	last birthday) Yrs.		Yaar If Undar 24 Hr Days Hours Mir	Month, De	th ay, Yaar) L/1920	Counti	aca (Stata or Foraig ry) •
	and *		Usual Rasidance of Dacedant  10a. Stata 10b. County		10c. Cit	ty, Town or Lo	ocation				10	Od. Inside City Limits
	Aaryti f sho	ō	MD BALTIM	ORE		N/A					10	1 ☐ Yas 2 ☑ No
	the 1288	Director	10e. Street and Number			,	10f. Zip Co	oda		10g. Citizan of	What Count	rv?
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21215-0020	d within 72 hours after death with the Maryland with 72 hours after death with the Maryland plane. The Medical Examiner must be notified at	by Funeral	11. Marital Slatus  1 Navar Married 2 Married  3 Widowed 4 Divorced	12. Was Dacadar Armed Forcas 1  Yas 2 If If Yas, Giva Yaar or Datas	nt Evar in U ? TNo		Was Decedan If Yas, specify	t of Hispanic Origin? ( Cuban, Maxican, Pua	Specify Yas or Norto Rican, atc.)		ce - Amarica ick, Whita, a	etc.
Ö	2 hou		15. Decedant's	Education		16e. Dece	dent's Usual C	Occupetion		16b. Kind of B		
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yla		2	RICHARD BROCK	MAN				MARY	QUEEN			
Jar	2 8 8 7		19a. Informant's Name/Raiationship					Straat and Numbar or F			, Stata, Zip (	Coda)
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g		BeC	25. Was casa referred to medical					26 Place of D	eath (Check only		1	1,00
$\geq$	Physician: rthis certific ral director,	To B	axaminar? 1 ☐ Yas 2 ☐ No	Hospital:	tiant 2	ER/Outpatian	nt 3D DOA	Other	Homa 5 ☐ Ras		har (Specify	•)
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Divis	ai or Attands after deat at Director:	Certification:	3 Sulcida 6 Could not datarmina	ba d 28a. Placa of I building,	njury - At h atc. <i>(Spacii</i>	oma, farm, sti	aat, factory, o	ffica	28f. Location City or To	(Straat and Num wn, Stata)	ber or Rurai	Routa Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Cartifiar 1 Certifying F (Check only one) 2 Medical Exa	Phyalcian: To the best minar: On the basis and manner:	of exemine	wiedge, deet tion and/or in	h occurred et l vastigation, In	the time, date and place my opinion, daath occ	e, end due to the curred at the time,	causa(s) and m dete and piece,	annar as sta , end due lo	ated. tha ceuse(s)
	To the within To the comple	M	29b. Signatura and titla of cartifiar	que				icansa number		29d. Data signal		
			30. Nema and addrass of person who	completed ceuse of	death (Iter	n 23e) (Type,	Print)					
			SINNARAJAH RA	GURAJ M	D. 2	2112 E	BELAIR	RD. FAL	LSTON,	MD. 210	)47.	

State Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 05 July 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 7. Age (In yrs. last birthdey) 5. Sociel Security Number laris 465 If Under 24 Hrs. | 8. If Under Birthplace (State or Foreign Country) 6. Sex 8. Dete of Birth , (Month, Day, Year) 10 M 20 F Months Deys Hours Min. 213-52-2632 Usuel Residence of Decedent 50 Yrs. 125,1771 anyard 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Pres 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 40 1202 5 A-14. Rece - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Status Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☑ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) th MA lursing cuft 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Sheary Cmmanuel ole 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 24 20b. Pleca of Disposition (Name of cametery, cremetory or other plece) Baltemore Commanuel 20a. Method of Disposition 20c. Location City or Town, Stete 1 Buriel 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Service 21. Signeture of Funerel Service 22. Name and Address of Fecility ouglass Fun 1701 mc Calloh St, Baltimore, MD. 21217 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each time. Approximate Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting In deeth) Due to (or es e consequenca of): Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of) 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 4 Unknown 1 Yes 2 No 3 Probably 24a. Wes en autopsy performed? 24b. Were autopsy findings eveilable prior to

**Physician** /Medical **Examiner** 

The law requires that the death certificete be executed

P.O. Box 68760.

Division of Vital Records,

**Physician** 

/Medical

Examiner

10a. State

Directo

Funerai

by

Completed

Be 2

**Funeral** 

**Director** 

permit. Peges 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "nature" any injury or other traumatic average.

Examiner

Physician/Medicai Be 10

physician end the buriei-transit 98 980 for certificate hes b lirector, page 2 s funeral Certification:

by Completed 25. Wes case referred to medical examiner?

1□ Yes 2 No

27. Menner of Deeth

1 Netural

3 Suicide

4 Homicide

(Check only one)

29b. Signetyre end title of certifier

n 24 hours efter des ne Funeral Director pletely filled in by the

To the Hosp within 24 hos To the Fune completely fi

After this

or Attending

Hospital

death. efter death Director:

5 Pending investigation 6 Could not be determined

Hospitel:

28e. Pleca of tnjury - At home, ferm, street, fectory, offica building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpetient

28b. Time of

28e. Dete of Injury (Month, Day Yeer)

3 DOA

MARIS AT BERG 26. Plece of Deeth (Check only one) STE //A Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOS DIC 28d. Describe how injury occurred 28c. Injury et Work? 1 Yes 2 No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

2 00

completion of cause of deeth?

2□ No

1 Yes

Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the bests of exemination end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner stated. 29d. Date signed (Month, Dey, Year)

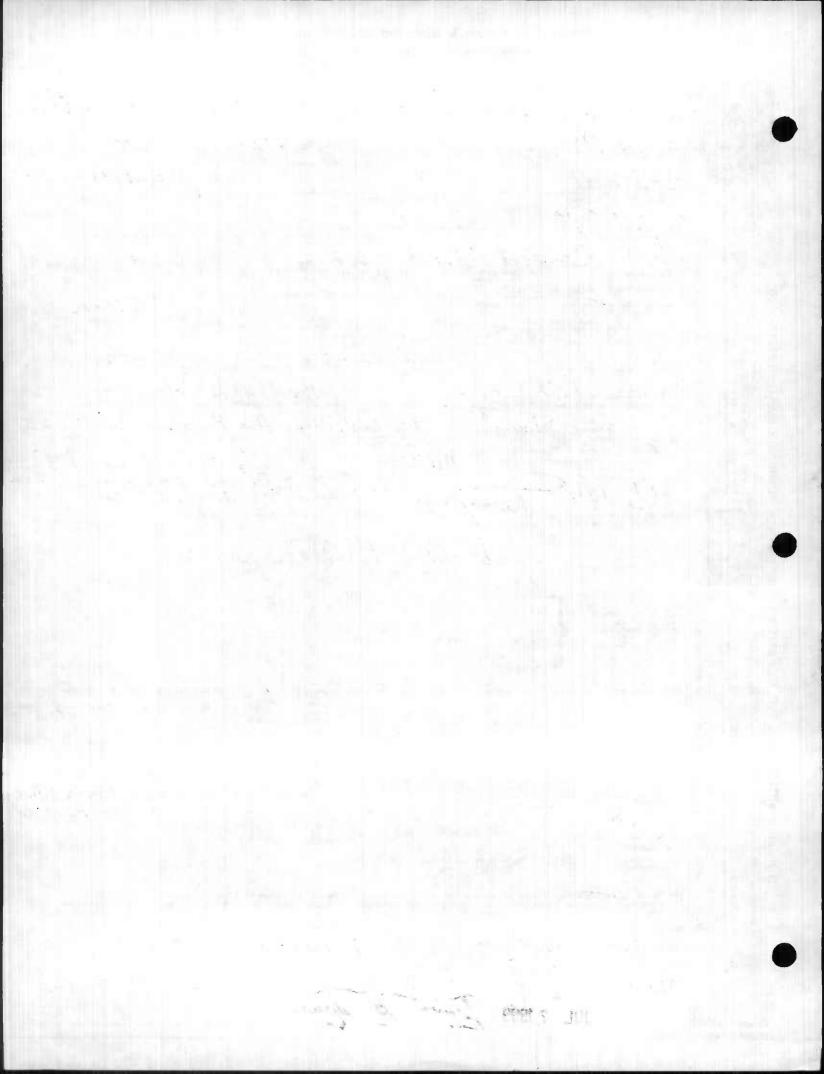
DW 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

BAHIMORE, RISEDA 30 31. Dete filed (Month, Dey, Yeer)

32. Registra's Signeture JUL

State Registrar

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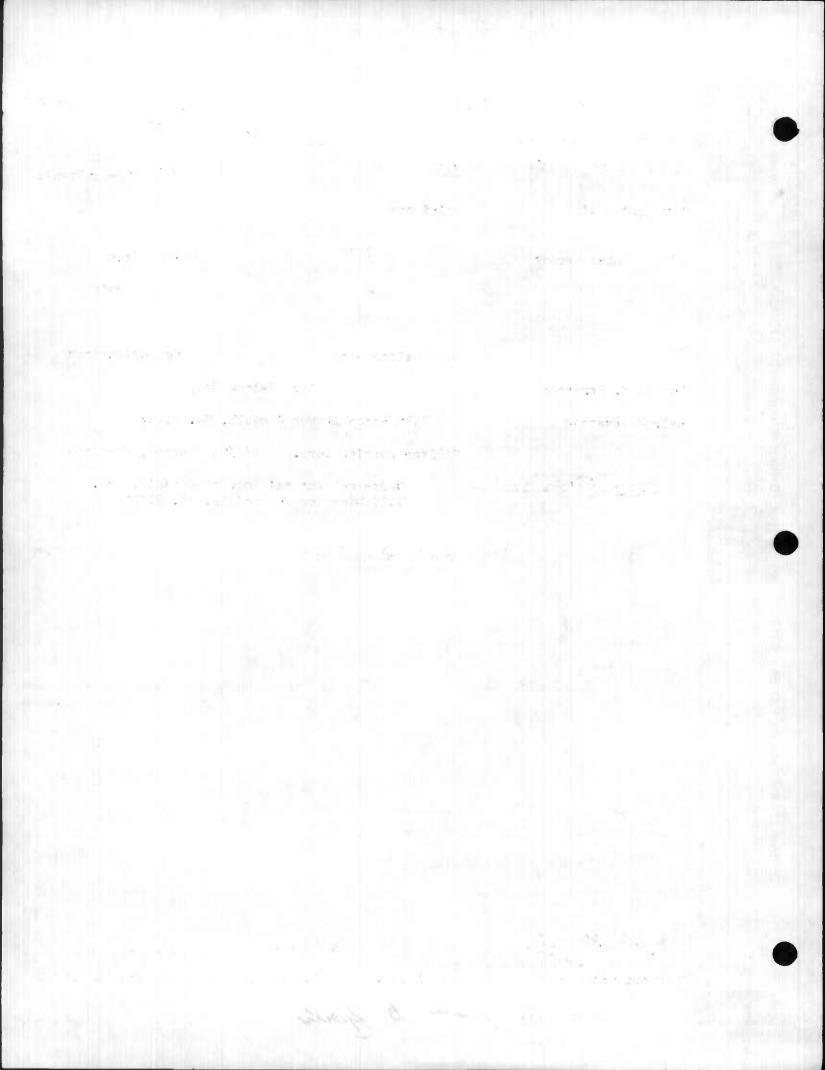
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	or 28a-f si	10e	. Street and Number				10f. Zip Coda			10g. Citizen	of What Cou	ntry?
020	urs after death val.; or itema 23a	17	746 Webster Stre Maritel Stetus 1∑ Never Married 2□ Married 3□ Widowed 4□ Divorced	12. Wes Decedent Armed Forces? 1 □ Yes 2 1 1 1 Yes, Give Yeer or Detes:			21230  Ves Decedent of Yes, specify Cut  Yes 2X No		(Specify Yes or Nerto Rican, etc.)	В	State Nece - Ameri Neck, White city: Wh:	can Indian, , etc.
21215-0020	ygiene. Ner than "natural, tre Medical.	12	15. Decedent's Et (Spacify only highest gre clamantery/Secondary (0-12)		i+)	(Give I life. D	ent's Usuel Occu kind of work done 10 NOT use retire	during most of w	vorking	16b. Kind of	Businass/ir	
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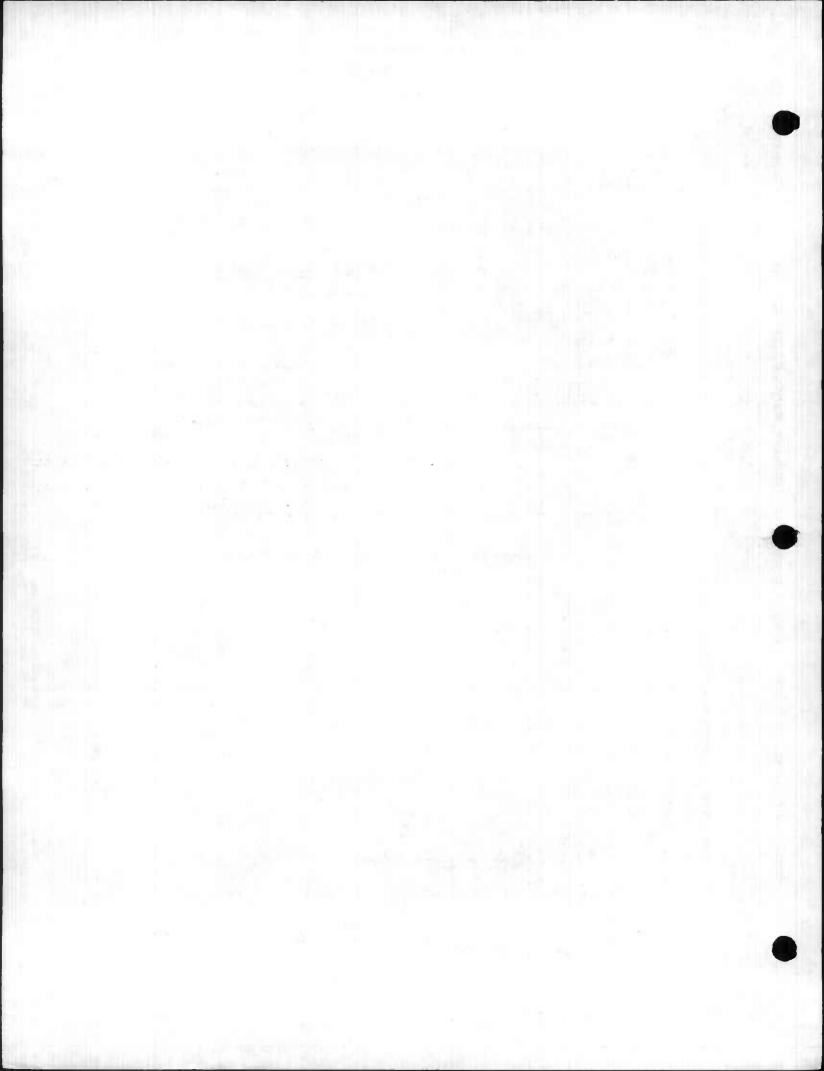
State of Maryland

/ Department of	Health and Mental Hygiene	99	21	33	

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To To	Harry Superczynski						1			Rose	Zorom	ski					
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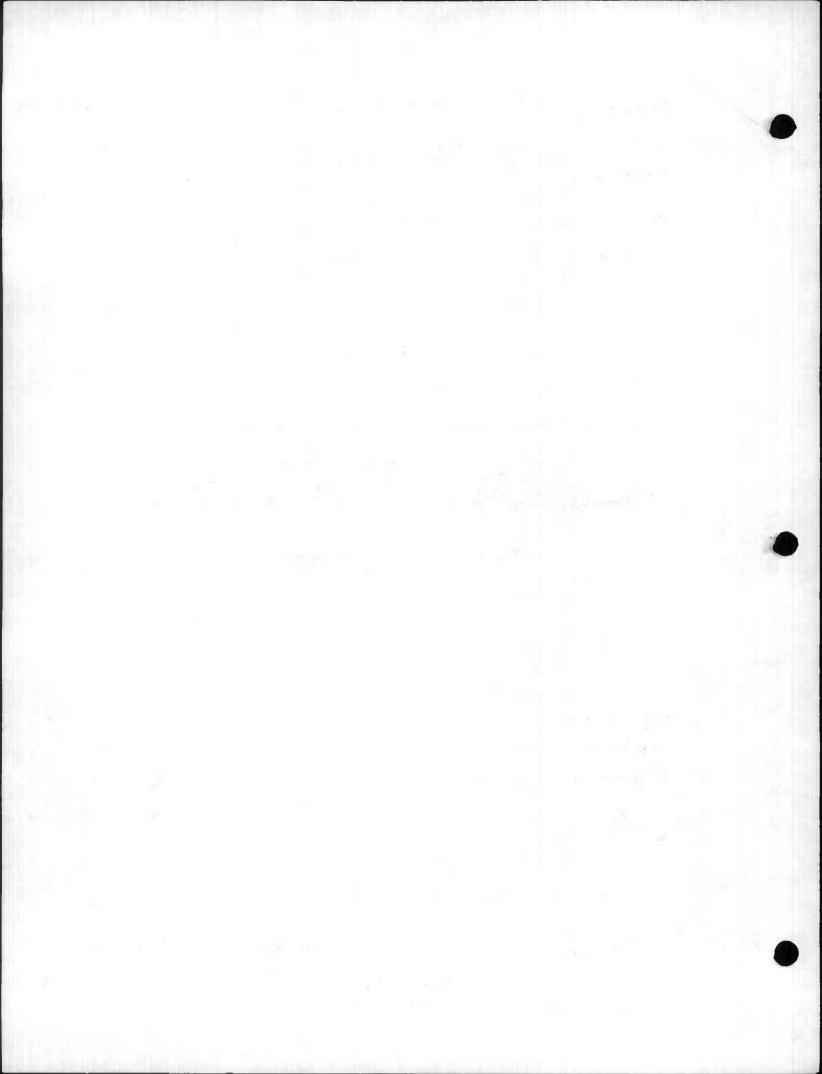
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Tima of Death Schallner Month **Physician** Donthu 2: SO AM /Medical 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Hospice of Baltimore Gilchrist Center Towson Baltimore 5. Social Sacurity Number if Under 1 Yaar If Under 24 Hrs. 8. Data of Birth (Month, Dey, Year) **Funeral** 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 1 M ATE Days Months Yrs. Director 21, 219-56-7034 Aug. Usual Residence of Decedent 10a. State 10b. County 28a-f show 10c. City. Town or Location 10d. Inside City Limits must be nothed Director 1 Tyes 2 No Baltimore Md. Timonium 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 6 41 Gorsuch Rd. 'natural', or items 23a 21093 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2% No If Yes, Give Year or Datas: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, atc. the Medical Examiner filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: by Specify 3 Widowad 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decadent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Hygiena. Elementary/Secondary (0-12) 12 College (1-4or 5+) Home maker Own home marked other 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme, . Pages 1 end 2 should be fill mant of Health and Mentel Heant: If Item 27 is marked oth lury or other treumstic even Charles Porter Rosina N. Cavey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Joseph G. Schaffner/husband 41 Gorsuch Rd. Timonium, Md. 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) Date 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from State Department of important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 7/3/99 Towson, Md. Dulaney Valley Memorial 21. Signature of Funeral Service LC 22 Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Intervel Between Onsat and Death **Physician** Immediate Cause (Finel disaasa or condition resulting in death) Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ician and buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Box 68760. physician Physician/Medical thet initiated events resulting in death) Last the Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. Completed by 24b. Were autopsy findings available prior to completion of causa of death? Lipidmia 24a. Was an autopsy 1 Yas 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatiant 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No funeral 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending n 24 hours after death.

He Funeral Director: Aft pletely filled in by the ful Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida 28e. Placa of Injury - At home, farm, straat, factory, offica building, etc. (Specify) Location (Street end Number or Rural Routa Number, City or Town, Stete) 4 Homicide 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of cartifier 29d. Date signed (Month, Dey, Year) D37133 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Osle Drive #209 Towson MD 21204 M. D. 7600 35 Registraria Signature State

DHMH 16 Rev 6/95

Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) ANNIE C 2. Deta of Deeth 3. Time of Death TURNER 2 gay TUPNE 1999 6:49 PM 4e. Fecility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE BALTIMORE CITY 111 N MONASTERY AVE. If Under 24 Hrs. 5. Sociai Security Number 7. Aga (In yrs. last birthday) If Under 1 Yaar 9. Birthplaca (State or Foreign PTRCINIA 10 M 20 F Months Hours 223-30-5916 81 Yrs. 7-12-1917 Usuet Residence of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits BALTIMORE 1 Yas 2 No 10e. Streel end Number 10f. Zip Code 10g. Citizen of Whet Country? 21229 U.S.A. 111 N MONASTERY AVE. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Detes: 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status Specify: AFR. AMERICAN 1 ☐ Never Merriad 2 ☐ Married 1 □ Yes 2 No Specify: 3 Widowed 4 Divorcad 16e. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantery/Secondary (0-12) Collega (1-4or 5+) DOMESTIC HOMEMAKER Fether's Name (Eirst, Middle, Last) LAWRENCE SIMMONS 18. Mother's Neme (First, Middle, Maiden Sumame) NAOMI CRUTCHFIELD 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 610 CENTRE AVE. NW ROANOKE VA 24016 19a. Informant's Neme/Retetionship (Type, Print) ROBERT SIMMONS

20c. Location - City or Town, Stete

Approximele

CROWNSVILLE MD

ESTEP BROTHERS FUNERAL HOME

-7-1999

**Physician** /Medical Examiner

**Physician** 

**Examiner** 

10e Steta

MD

20a. Mathod of Disposition

4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Eureral Service Licen-

1 Burial 2 Cremetion 3 Ramovel from Stata

**Funeral** 

Director

or 28a-f show

items 23a

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"natural".

traumatic event, the Medical

permit. Pages 1 and 2 should be filed within 72. Depertment of Health and Mentel Hygiene. Important: If item 27 is marked other than "natt any Injury or other traumatic event, the Modical page.

Baltimore, Maryland 21215-0020

Examiner must be notified at

Director

Funeral

by

Completed

Be

2

/Medical

Completed by Physician/Medical Be Medical Certification: To To the Hospital or Attendi within 24 hours efter deeth To the Funeral Director: A completely filled in by the fi

Division of Vital Records, P.O. Box 68760,

PRINCE, OF HARM SERVICE. LIST ONLY	one cause to lead line.				Onset end Deeth
Immediata Causa (Finei disaasa or condition resulting in death)	· carbin	or as a densequence of	arrie	*	
対対対に対応を対さ	Brown	astr	me		
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thet initiated events resulting in deeth) Lest	d.	or es a consaquança of	):		
Pert II. Other algnificant conditions	contributing to death but not res	sulting in the underlying	causa givan in Part I.	23b. Did tobacco use co	ontribute to the cause of death
				24e. Wes en eutopsy performed?	24b. Wara autopsy findings evellebile prior to completion of ceusa of deeth?
25. Was cese rafer ed to medical exeminer?			26. Pteca of De	eath (Check only one)	
1 ☐ Yes 2 No	Hospitai: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□ I	OOA Other: 4 Nursing	Home 5 Residence 6 □Oth	ner (Specify)
27. Manne of Deeth  1 Poeturet 5 Pending 2 Accidant tovastigation		28b. Time of Injury	28c. Injury et Work? 1 Yes 2 No	28d. Dascribe how injury occur	red
3 Suicide 6 Could not to determined		ome, farm, streat, factory)	ory, office	28f. Localion (Street end Numb City or Town, State)	ber or Rurel Route Number,
29a. Certifier (Check only one)	hysicien: To the best of my known miner: On the best of examine end menner stated.	owiadge, death occurre ation and/or investigation	d at the time, data and place on, in my opinion, daath occ	e, and dua to the cause(s) and mo urred at the time, data and place,	anner as steted. and dua to the cause(s)
29b. Signature end title of certifier	Lucilal	2	9c. Licanse number  D 2 0 5 4 7	29d. Date signe	d (Month, Day, Year) -07-99

20h. Piece of Disposition (Name of cemetary, cramatory or other placa)

OROWNSWILLE VA CEM

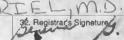
Name and Address of Facility

1300 EUTAW PLACEBALTIMORE

State Registrar

31. Data filed (Month, Dey, Yeer) JUL 0 7 1999

30. Name and address of person who complated ceuse of death (tram 23a) (Type, Print)



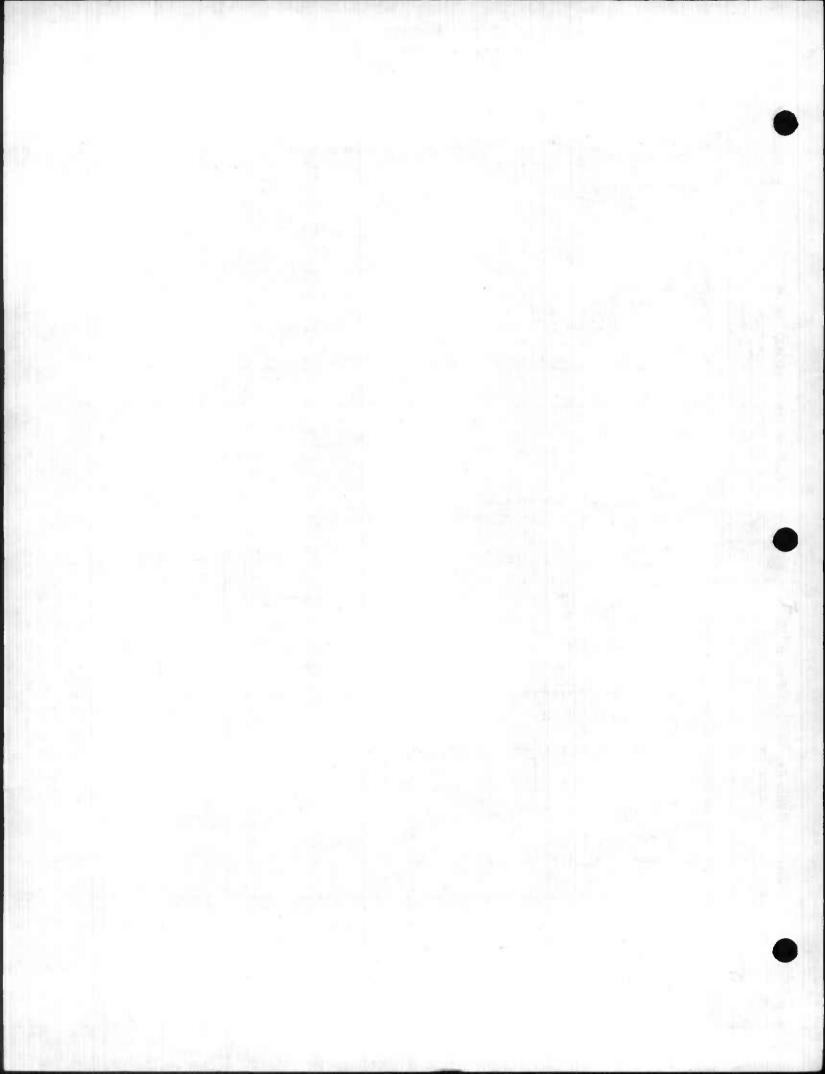
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DHMH 16 Rev 6/95

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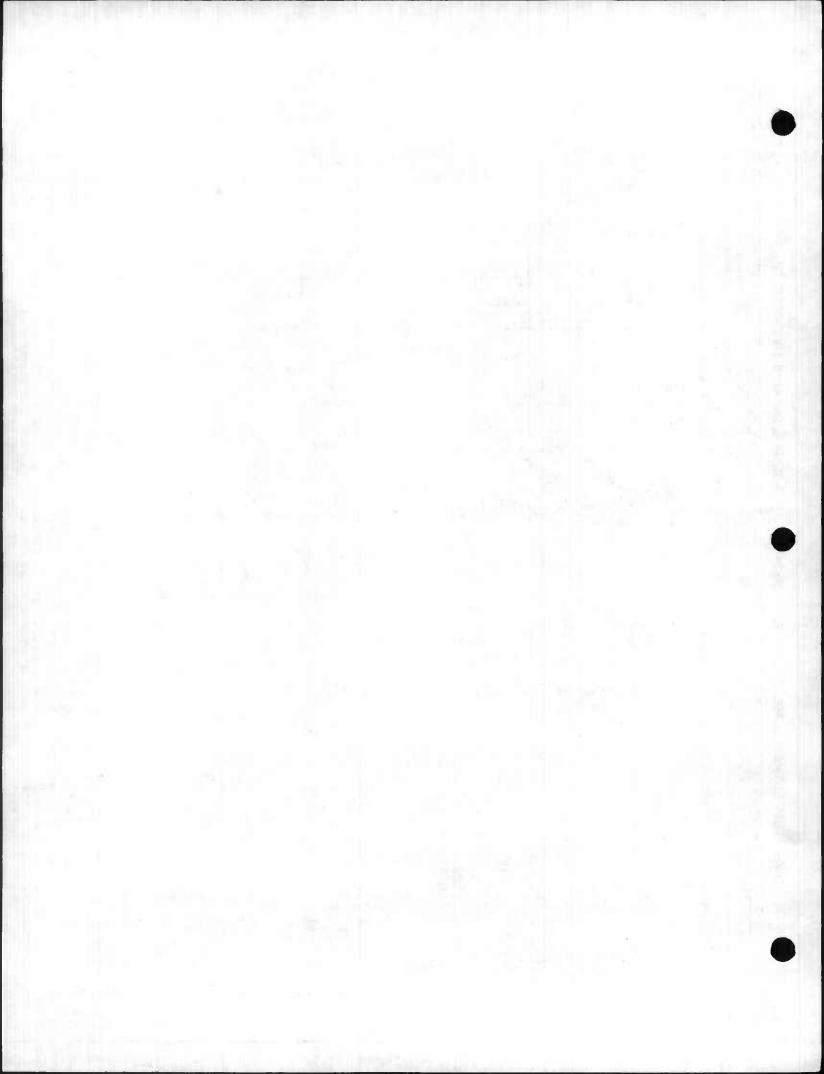
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1 Decedentia Nama (First Middle Last		(	Certificate of	Death	2. Date of De	nog. No.	213	3 0	
Decedent's Name (First, Middle, Last)     CATHERI		TATE			Month 6	Day 30	Yeer	na of Death	
4a Fscility Name (If not institution, give :				4b. City, Town, or L					
FRANKLIN WOODS			day) If Under 1 Year		imore		timore		
5. Social Security Number 6. Security Number 218-01-9822	M 2√2 F	Adventure Day of Marine I Adventure I				th y, Year)	9. Birthplace (St. Country) Maryland	ite or Foreign	
10a. State 10b. County	1	0c. City, Town	or Location				10d. Inside City Limit		
Maryland Baltimo	re		White	Marsh			10	Yes 2 No	
10e. Street and Number			10f. Zip Code			10g. Citizen of V			
5813 Gambrill Road				62 Hienenic Origin? (Si	pacify Vac or No	U.S.	A . - American India	n	
1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No No No Sp			Rican, etc.)	Blac	k, White, etc. :White	110	
15. Decedent's Edu		16a. Decedent's Usual Occupation (Give kind of work done during most life. DO NOT use retired)			kina	16b. Kind of Bu	siness/Industry		
Elementary/Secondary (0-12) 8th Grade	College (1-4or 5+)		We. DO NOT use retire Homemaker	od)		Own	Hama		
17. Father's Name (First, Middle, Last)			nomemaker	18. Mother's Nen	ne (First, Middle				
Charles Deems				Minnie	Be	rtrand			
19a. Informant's Name/Relationship (Ty			Mailing Address (Stree						
Mr. Harry T. Tate	-		813 Gambri Disposition (Name of	ce Rd., W	nite Ma		21162 City or Town, Stat		
1 ☐ Burial 2 ☐ Cremetion 3 ☐ R		cemetery	cremetory or other ple Hill Mem'l						
4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	90	noccy	22. Name end Addr	ess of Facility				Lana	
Beria a. U	Jellem		Schimun	ek Funera lair Rd.,	l Home,	Inc.	21236		
23a. Part1. Enter the disease, or complishock, or heart feilure. List only or	cations that caused the cause on each line.	e death. Do no	t enter the mode of dy	ng, such es cardiac	or respiretory a	rrest,	Approx	imete I Between and Deeth	
Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):									
resulting in death) Last	1.			1.60					
Part II. Other significant conditions con	tributing to death but r	not resulting in	he underlying cause gi	ven in Pert I.	23b. Did tobecco use contribute to			use of death?	
Hypertension	1				1 ☐ Yes 2 ☒ No 3 ☐ Probet			4 🗆 Unknows	
Arterioscler	cotic Hea	rt Dis	sease		24a. Was	an eutopsy ormed?	24b. Were suto aveilable p completion of death?	rior to	
					10	Yes 20 No	1 🗆 Yas	2□ No	
25. Was case referred to medicat examiner?	lospital:		Ot	26. Place of Dec					
1  Yes 2⊠ No	1 L Inpatient 28a. Date of Injury	28b. Ti	BRITISH 3LL DOX	4423 Mulaing n		dence 6 Other			
1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	'ear) Inj		ork? ]Yes 2□No					
3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, ferr	n, street, fectory, office		28f. Location ( City or To		er or Rural Route	Number,	
		caminetion and	death occurred et the to or investigation, in my					ıse(s)	
29b. Signature and title of certifier	)	260	29c. Licen			29d. Date signed	i (Month, Day, Ye	ar)	
prong		M.D.	D]	7728		June 3	0, 1999		
30. Name and address of person who co Ba Yin Oung,			ype, Print) Belair Ro	i. B	alto.,	MD 2:	1236	4-15	
31. Date filed (Month, Day, Year) JUL 0 7 1999		0022	DCIGII IN		/				



1. Decedent's Name (First, Middle,	Last)		ertificate of		2. Dale of Death	. No.	3. Ti	na of Death
Unknown 99-104					Month	Dey	Year	
la Facility Name (If not institution,	give street and number)			4b. City, Town, or Lo	May 17 cation of Death	4c. County		13 A.M.
200 Block of No	2017/00/2017	oot		Dolltimor				
	i. Sex 7. Age (	eet. In yrs. last birthd	y) If Under 1 Year		8. Date of Birth	N/	9. Birthplace (S Country)	tate or Foreign
unknown	1□M 2OF unkr	iown Yrs	Months Days		(Month, Day, Younknown		unknown	
Usual Residence of Decedent								
10a. State 10b. County	'	Oc. City, Town or	Location				1	de City Limits
unknown unknown	n	unknown					unkno	Yes 2 No
10e. Street and Number			10f. Zip Code		10g	. Citizen of V	What Country?	
unknown			unknow			known		
11. Marital Status Unknown	12. Wes Decedeni Eve Armed Forces? U	er in U.S. Inknown	<ol><li>Wes Decedent of I If Yes, specify Cub</li></ol>	Hispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No- Rican, etc.)		e - American Inde ck, White, etc.	en,
1 Never Married 2 Married 3 Widowed 4 Divorced	d 1 Yes 2 No If Yes, Give Year or Detes:		1□ Yes 2□ No	Specify:		Specify	black	
			unknown	nation	16	h Kind of Bu	ualness/Industry	
15. Decedent's (Specify only highest)	grade completed)	(G	cedent's Usual Occup ive kind of work done b. DO NOT use retire	during most of workir	ng 16	o. AND UI DI	uen rees/irruustry	
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17. Father's Name (First, Middle, La			IIIVIIIVIII	18. Mother's Name	THE R. LEWIS CO., LANSING, MICH. 49, 100, 100, 100, 100, 100, 100, 100, 10	inknow iden Suman		
unknown				unknown				
19a. Informant's Name/Relationship	o (Type, Print)	19b. M	ailing Address (Street	t and Number or Rura	I Route Number, C	City or Town.	State, Zip Code)	
unknown			nown				, _,,	
20a. Method of Disposition	-	20b. Plece of Di	sposition (Name of		Date 20	c. Location -	City or Town, Sta	te
1 Burial 2 Cremetion 3 4 Donation—S Other (Spe		cemetery, c	remetory or other pla	ice)				
21. Signature of Funeral Service Lic			22. Name end Addre	ess of Facility				
Ronald	S. Wade, Dir	ector	State Anat	omy Board	, 655 W.	Balti	more Str	eet
23a Part1. Enter the disease/or co	and the lines that caused the		Baltimore,				Appro	ximate
Immediate Cause (Final	1	1.1.1.	- 1-					
disease or condition resulting in death)	a. Du	e to (or as a con	sequence of):	omy opath	ly			
resulting in death)	b	e to (or es a con	sequence of):	omy opath	ly			
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State Registrar



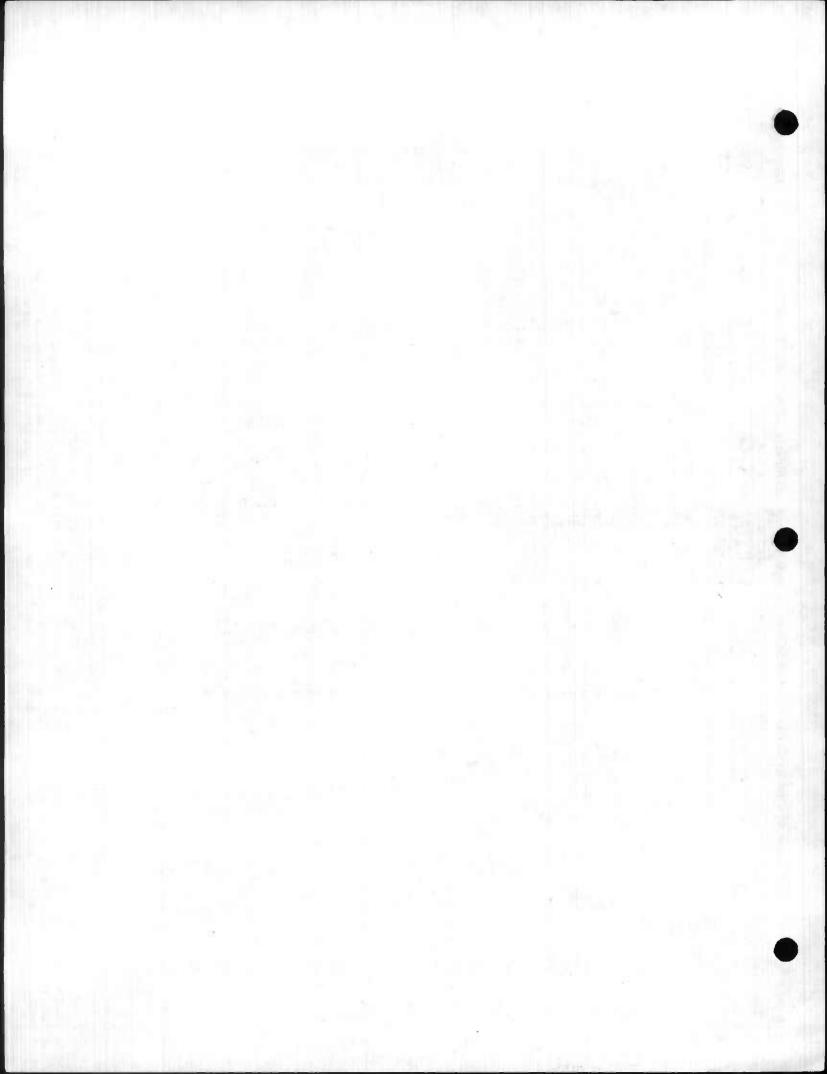
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 1999Year **Physician** July 6, George E. Weber 5:45 A.M. /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mariner Health Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Dete of Birth 9. Birthplace (St. Oct. 18, Year) 21 Mary I and 9. Birthplace (State or Foreign **Funeral** Days 1⊠M 2□ F Months Hours 220-07-5065 77 Director **Usual Residence of Decedent** the Manyland 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits ahow r 28a-f ahow 1 Yes 2 No Maryland Director Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WITH than "natural", or items 23s or the Medical Examiner must be a 1626 South Shore Parkway 21122 United States Pages 1 and 2 should be flied within 72 hours after deeth nant of Heelth and Mentel Hyglens.
Int: If Nem 27 Is marked other than "natural", or Nema 23.
Inty or other treumatic event, the Medical Examinationals. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Merried 2 ☐ Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cable Splicer Bell Atlantic Baltlmore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 8 George Weber Nellie Dunnock 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Weber/Wife 1626 South Shore Parkway Pasadena, MD 21122 20s. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State July 8, 1 Burial 2 ☐ Cremetion 3 ☐ Removet from Stete pemit. Page Department of Important: If eny Injury or page. 4 ☐ Donation / 5 ☐ Other (Specify) Glen HAven Mem. Pk. 1999 Glen Burnie, MD 21. Signature of Fineral Service License 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home P.A. 421 Crain Hwy. S.E. Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one course on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel Syeer disease or condition resulting in death) Examiner Examiner g physician and es the burlal-transit or Attending Physician: The law requires that the deeth certificate be executed Sequentially fist conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 154Pals Severe dixxuse

Due to (or as a consequence of): Box 68760. Physician/Medical 485 signed by the a P.0. Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24a. Was an autopsy performed? Were autopsy findings available prior to completion of cause page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No cortificata funeral director. 25. Was case referred to medicel examiner? 8 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ŽŽ No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Netural a Euneral Director: After the function of the 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 ş 29b. Signature and title of certifier Attending 29d. Date signed (Month, Day, Year) 29c. License number D44973 Thysicial July 6, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 325 Hospital Drive 202, Glen Pourie GURMEET S. SAWHNEY, Mary Jland MD-21076 31. Date filed (Month, Day, Year) 1999 32. Registrar's Signeture State Registrar

T DI



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** WORTH SYMA 6:20AM JUNE 30,1999 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FutureCare-Chesapeake Anne Arundel
9. Birthplace (State or Foreign
Country) frunder 24 Hrs. If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1□ M 2∏ F Yrs. Director 213-46-8252 28.1915 Michigan Usual Residence of Decedent 10a, Slete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f show solical Examiner must be notified at 1 Yes 2 No Director Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21401 1930 Severn Grove Road Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or ite any Injury or other traumatic event, the Mexical Examina page. 1 Never Merried 2 Merried 1 Yas 2XXVIII Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 17. Fathar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Oscar Klemola Anna Young 2 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1930 Severn Grove Rd., Annapolis, MD 21401 Ardella Rohrhock (Daughter) 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Removel from State 4 □ Donation 5 □ Othar (Specify) Baltimore National Cemetery 07/06 Baltimore, MD 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 21. Signeture of Funeral Service Licensee 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. MI **Physician** the /Medical Immediate Cause (Fine) as emme disease or condition resulting in death) **Examiner** Due to (or es a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of) 68760. Physician/Medical Due to (or es a consequence of) Box P.O. P signed by the a Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Wursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 MNatural 28d. Describe how injury occurred 28b. Time of 28c. Injury el Work? 28a. Date of Injury (Month, Day Year) 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 4 - Homicide To the Hospital or within 24 hours sft To the Funeral Di completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifian 29d. Date signed (Month, Day, Year) 29b. Signature and fitle of certifier 29c. License number 6.30.1999 Altending Docter 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) V. CYRIAC M.D 8109 RITCH 12 ANY, 31. Data filed (Month, Dey, Year) 32. Registra/ USignature State Registrar

DHMH 16 Ray 6/95

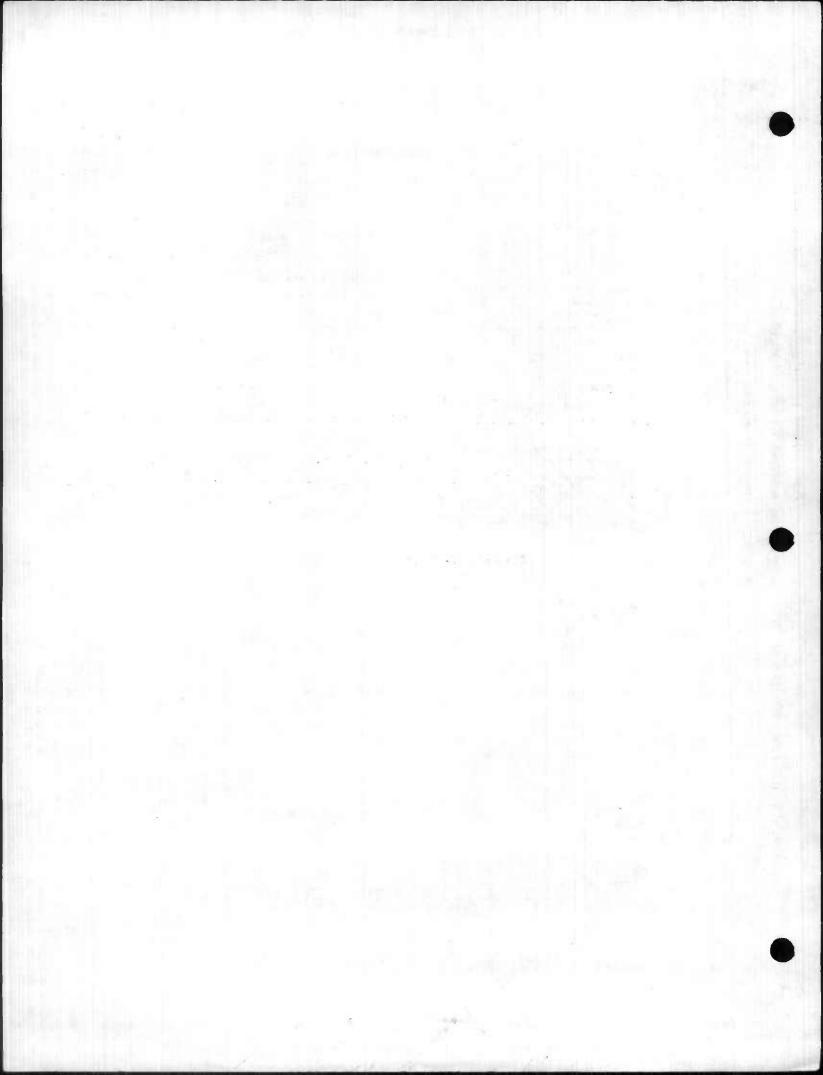
State of Maryland / Department of Health and Mental Hygiene

			Cer	tificate of	Death		Reg. I	No.	5 6	1341
	1. Decedent's Name (First, Middla, L						of Death		Vaar	3. Tima of Deeth
sician		Mable	Margare	t Wiscot	t	Ju	ly 4,	1999	Yaar	12:10
edical miner	4a Facility Nama (If not institution, g	ive street and number)			4b. City, Tow	m, or Location of	-	4c. County	of Death	
	Stella Maris Ho	ospice			Tows	on		Balt	timore	e
ral		Sex 7. Aga (In yr	s. last birthday)	If Under 1 Yaar Months Devs	If Under 2 Hours		of Birth	ac)	9. Birthple	ece (Stata or Fora
or	220-24-4226 Usual Rasidance of Decedent	1□ M KNF 71	Yrs.	Moritis Deys	Hours	Ma	y 30,1	928	Peni	nsylvani
	10a. State 10b. County	10c. C	City, Town or Lo	cation			25/		10	d. Inside City Lim
To Be Completed by Funeral Director	Marriand Bal	timore		D.	unda1k					1 ☐ Yes 2 🐼
Director	Maryland Balt  10e. Street and Number	CIMOLE		10f. Zip Code	diraci.		10g.	Citizen of W	Vhat Count	ry?
0	1936 Stanhope Ro	had			21222		Ur	nited	State	es
Funeral	11. Marital Status	12. Was Decedent Ever in	U,S. 13. V	Wes Decedent of I- I Yas, specify Cubi	lispanic Orig	in? (Specify Yes	or No-		e - Amarica	
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by	3 ☐ Widowed 4 ☐ Divorced	If Yas, Give Yaar or Datas:	1	1 □ Yas 2 ☒ No	Specify:			Specify	White	е
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ToB	William Love					Unknown	1			
-	19a. Informant's Name/Relationship	(Type, Print) Husband	19b. Mailin	ng Addrass (Street	and Number	or Rural Routa	Number, Cit	y or Town,	Stata, Zip	Code)
	Mr. Frederick			6 Stanho	pe Roa	ad Dund	alk,	Maryla	and	21222
	20a. Mathod of Disposition		Place of Dispos	sition (Nama of natory or other place	cel	Deta	20c.	Location -	City or Tov	vn, Stata
	1 Burial 2 Cramation 3			iem. Gdsn		7/1999		Bel A	ir. M	aryland
	21. Signature of Egneral Service Sco		11		.,	1				
	1/2.10	WIL	/	Name and Addra Duda-Ru						
-	1241	1700		7922 Wi			lalk,	Maryl	-	
	23a. Farti. Entar tha disaase, or con shock, or heart failura. List only	y ona cause on each lina	arti. Do not ont	or the mode or dyn	ig, such as c	ardiac or raspire	itory arrast,			Approximate Interval Batween Onset and Death
ו										Oriset and Death
	Immediata Causa (Final diseasa or condition	a _RECTOSIGMO	TD CANC	ER						
	rasulting in death)		(or as a conseq							
ine									i	
Examiner	Sequentially list conditions,	Dua to	(or as a conseq	uance of):					1	
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edicai	that initiated evants rasulting in death) Last	Due to	(or as e consequ	uanca of):						
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lan		d								
Sic	Part II. Other significant conditions	contributing to deeth but not re	asulting In tha ur	ndariying causa giv	van in Part J.	231	b. Did tobac	co una cor	ntributa to	the cause of des
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ted	1361					248	. Wes an au		ava	re autopsy finding ilable prior to
Completed						_			of d	nplation of causa leath?
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Certification:	1 Natural 5 Panding 2 Accidant invastigation	(Month, Day Year)	Injury		rk?  Yas 2□N	lo				
fice	3 ☐ Suicide 6 ☐ Could not	d 286. Placa of Injury - At	homa, farm, stre	eet, factory, office					er or Rural	Routa Number,
ert	4 Homicide	building, atc. (Spec	cify)			City	or Town, St	ale)		
ai C	29e. Certifier 1X Certifying P	hysician: To the best of my kr	nowledga, death	occurred at the tir	me, date and	place, and dua	to the cause	(s) and ma	nner as ste	eted.
edicai	(Check only 2 Medical Exa	miner: On the basis of axamir and menner steted.	nation and/or inv	astigation, in my o	pinlon, deeth	occurred at the	time, date	and placa, i	and due to	the cause(s)
Me	29b. Signeture and titla of contifier			29c. Licens	sa number		29d.	Date signed	d (Month, E	Day, Year)
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	t pp Name and address of access the	completed causa of death (Ite	em 23a) (Type, I	Print)						
	DR. TARIQ MAHMO	OOD 2300 DULA			TIMON	IUM, MD	21093			
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ate rar	DR. TARIQ MAHMO	OOD 2300 DULA		LEY RD.	TIMON	IUM, MD	21093			

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth **Physician** Month Octavia Zeigler 11:10pm July 01, /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** 3002 Mathews Street Baltimore 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) **Funeral** 1 M 2 KF Months Days 213-32-0098 66 Yrs. **Director** 06-277-33 MD Usual Residence of Decedant the Marylend 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow items 23s or 28s-f show MD NA Director Baltimore 1 Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with 3002 Matthews Street 21218 USA Funeral deeth 12. Wes Dacedent Ever in U,S. Armed Forces?

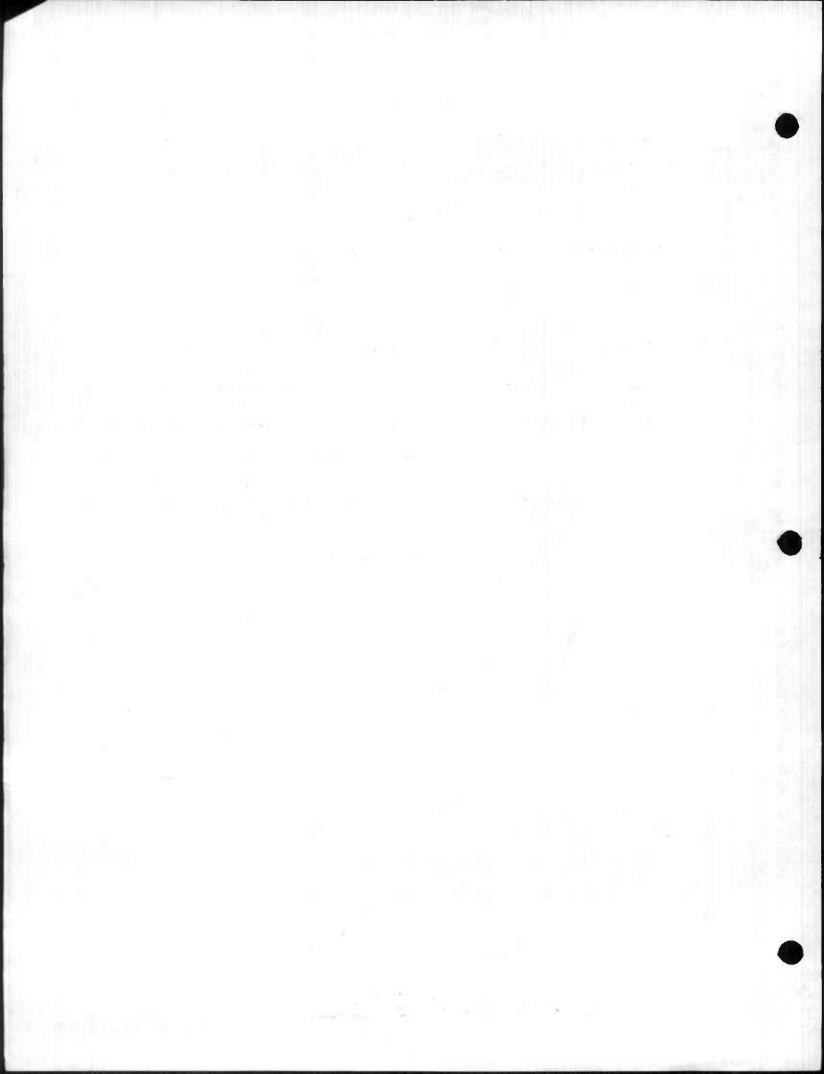
1 ☐ Yes 2 ☐ No if Yas, Give Yeer or Detes: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Meritel Status the Medical Examiner filed within 72 hours efter 1 ☐ Never Married 2X Married 21215-0020 9 1 ☐ Yes ŽÍNo Specify: þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced naturel Completed 15. Dacedant's Education Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than " Eiamantary/Secondery (0-12) Collaga (1-4or 5+) Domestic llth Grade Omni Hotel NA Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surname) . Peges 1 and 2 should be fill ment of Health end Mental Hant: If Item 27 is marked oth jury or other traumatic even Be Andrew Watson Katherine Sommerville 19e. Informent's Neme/Ralationship (Type, Print) 19b. Meiling Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) Sterling Zeigler 3002 Matthews Street Baltimore, MD. 21218 20e. Mathod of Disposition 20b. Plece of Disposition (Name of cemetery, crametory or other plece) 20c. Location - City or Town, Stete N□ Buriel 2 □ Cremetion 3 □ Removal from State permit. Pege Depertment of Important: If any Injury or once. Garrison Forest VA Cem. 07-07-99 Owings Mills 4 ☐ Donetion 5 ☐ Other (Spacify) 21. Signatule of Funerel Service License 22. Neme end Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23e. PertY. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or haart failura. List only one cause on each line. Approximete intarval Batween Onset and Deeth **Physician** /Medical Immediata Cause (Finel LUNI CAMER diseese or condition resulting in daath) 1 MONTH Examiner The law requires that the death certificate be executed the buriel-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest and Due to (or es e consequence of): Box 68760. ettending physiclan Physician/Medicai Due to (or as e consequence of). ed by the el detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3√ Probably 4 Unknown signed b by should should 24b. Ware eutopsy findings eveileble prior to completion of ceuse of daeth? Completed 24e. Wes en eutopsy performed? certificate 1 Yas 2 No 1 Tyes 2 No. al or Attending Physician: T s efter death. Il Director: After this certificat ed in by the funeral director, pi Be 25. Was case rafarred to medical exeminer? 26. Pleca of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 27. Manner of Deeth 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 5 Panding 1 Naturel Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, ferm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicida To the Hospital within 24 hours e Hospital edical 29a. Certifier 🐿 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) end mannar es steted. (Check only one) 2 Medical Examiner: On the basis of exemination end/or investigetion, in my opinion, deeth occurred at the time, date end piece, end due to the causa(s) end menner steted. 29b. Signeture end title of certifier 29d. Date signed (Month, Dey, Year) death (Itam 23a) (Type, Print) 4940 JHBVML PURTEA EATER AVE PAUTINONE MI LHARL

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State Registrar 31. Dete filed (Month, Day, Ye.

32. Reginter's Signeture

7 1999



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death na of Death Day **Physician** JAMES ATKINSON 0146 JUNE 11, 6995 /Medical 4b. City, Town, or Location of Death 4a Facility Nema (If not institution, give street and number) 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 7. Aga (In yrs. last birthday) If Under 1 Year 6 Sex 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) **Funeral** 1⊠M 2□ F Months Days Hours Yrs. 21824 4225 **Director** July 8, 1927 Pennsylvania Usual Rasidanca of Decedant tha Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified as 1 ☐ Yae 2 ☑ No Directo Maryland Wicomico Mardela Springs 10e. Street and Number 10f. Zip Coda 10g, Citizen of What Country? with 25028 Delmar Rd. 21837 death 1 Funerai USA 12. Wes Decedent Ever in U,S. Armed Forcas? 13. Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Raca - American Indian, 11. Maritel Stetus Black, Whita, atc 72 hours aftar 1 XYas 2 No If Yas, Giva 1 ☐ Navar Marriad 2 ☑ Married 1 Yas 2X No Specify: Specify à 3 ☐ Widowed 4 ☐ Divorced White Year or Datas: WW II Completed 15. Decadant's Education (Specify only highast grade completed) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry filed within Elamentery/Secondary (0-12) Collage (1-4or 5+) Hygiane. Delmarva Oil Co. Marketing Representative 12 17. Fether's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumeme) Be Pagas 1 end 2 should be 1 nent of Haalth and Mental I Joseph Atkinson Martha Kennedy 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Steta, Zip Coda) Dorothy A. Atkinson/Wife 25028 Delmar Rd., Mardela Springs, MD 21837 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ⊠ Burial 2 □ Cremation 3 □ Ramoval from State = b Department 5 Other (Specify) 4 ☐ Donation Mardela Memorial Cemetery 6/15/99 Mardela Springs, MD Funeral Servica Licans 22. Nama and Address of Fecility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part . Enter the disaesa, or complications that cause the death. Do not anter the mode of dying, such as cardiec or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** ASPIRATION PAEUMONIA /Medical Immedieta Causa (Final disaasa or conditio rasulting in daath) Examiner Examiner physician and the burial-transit requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiate causa. Entar Undarlying Causa (Disaasa or Injury that initiated avants resulting in deeth) Lest Dua to (or as a consaguanca of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es a consaquanca of) 88 signed by the all Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 1 Yee 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy Completed completion of cause of death? paga 2 No 1 ☐ Yas 1 ☐ Yas 2 ☐ No certificate 25. Was casa referred to medical examinar? Be 26. Place of Daath (Chack only ona) Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 2 1 Yas 2 No 1 Impatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funerel 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: Aftar or Attending 1 Naturel 5 ☐ Panding aftar daath. Director: Aft 1 Yes 2 No invastigation 2 Accidant 6 Could not be 3 Sulcida 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Spacify) filled in by 4 ☐ Homlcide 24 hours a Funerei C Hospital 29a. Certifier 🖼 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, and dua to the ceuse(s) and manner as stated. Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigetion, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d, Data signed (Month, Dav. Year) 29c. License number 10411A 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) PENINSULA MED. CTR SALISBURY EMMANUEL H AZV REG. 31. Date filad (Month, Day, Year)
JUN 1 5 1999 State Registrar



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State of Maryland / Department of Health and Mental Hygiene 99 21341

						Cer	tificate d	of Death		Reg. No.	) in	1044
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	Physiciar /Medica	_	Florence A	A	llen				6	71	99	1712 PM
	Examine		4a Facility Name (If not institution, give	street and number)				4b. City, Town, o	Location of Death	4c. County	of Death	
			Carroll County					Westm	inster		rrol	
	Funeral Director		5. Social Security Number 6. Security Number 160-50-8463 Usual Residence of Decedent	TM 24F34F MT	e (In yrs. Ia LO5	rst birthday) Yrs.	Months Da			y, Year)	9. Birthp Coun	lace (State or Foreign try)  MD
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	r 28	Director	10e. Street and Number			·	10f. Zip Cod	e		10g. Citizen of V	What Coun	itry?
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	e E	runeral	11. Marital Status	12. Wes Decedent I Armed Forces?	Ever in U,S	5. 13. W	/as Decedent Yes, specify C	of Hispanic Origin? ( Juban, Mexican, Pue	Specify Yes or No-	14. Rac	e - Americ	
21215-0020	or of	2	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Detes:	lo		□Yes 2√∑I			Specify	/:	ack
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12	within then.	Ē	Elementary/Secondary (0-12)	College (1-4or 5	+)		O NOT use re	tired)		-		
			17. Father's Name (First, Middle, Last)			Na	anny	19 Mathara Na	ame (First, Middle,	Dome:		
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re,	Office of the second	- 1-	20a. Method of Disposition	niece	20b. Pla	Westr	ninst c	r, MD 2:	1157 Date	20c. Location -	City or To	wn, State
ano m	80= 5		1 Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)				atory or other		0.405.40	N 717		1 2470
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60,	Cien Cien		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	c								
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_	the Hospital or hin 24 hours after the Funeral Dir upletely filled in		29a. Certifier 1 Certifying Phy	sician: To the best of	f my know	ledge, daath	occurred at the	e time, date and place	e, and due to the	cause(s) and ma	anner as si	tated.
	n 24 hou n 24 hou he Fune pletely fil	200	(Check only 2   Medical Exami	ner On the basis of and manner sta	examination	on and/or inve	estigation, in n	ny opinion, daath occ	curred et tha time,	data and place,	and dua to	tha causa(s)
	Within To th comp		29b. Signature and title of certifier	/			29c. Lic	ense number		29d. Date signe	d (Month,	Day, Year)
			( ) /K	NA	_		1	> 2520	3	6/2	21/	5.5
		1	30. Name and address of person who co	empleted cause of de	eath (Item 2	23a) (Type, F	rint)200 N	lemorial A	ve., Wes	tmingte	r, MD	21157
			C.T. MO6	2ROW	MD	, CA	2006	1 000	NTY	GENE.	RAL	HOSP.
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month **Physician** 19 2135 06 99 **BEAUCHAMP** M /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Dete of Birth (Month, Day, Year) **Funeral** 1□ M 21 F Days Hours Yrs. MARYLAND Director 88 219-36-5801 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be spotted at 1 Yes 2 No MARYLAND SOMERSET PRINCESS ANNE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 30458 PRINCE WILLIAM STREET 21853 Funeral 12. Wes Decedent Ever in U.S. Armed Forces?,
1 Yes 2 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Bleck, While, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE à 3 ₩ Widowed 4 Divorced Completed 15. Decadent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Rusiness/Industry College (1-4or 5+) Elementery/Secondary (0-12) 12 **TEACHER EDUCATION** 5+ permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other treumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIAM JOHN COULBOURN EMMA A. STERLING 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) TOMMIE LEE DINGBAUM/NIECE 1827 WOODRAIL DRIVE, MILLERSVILLE, MD. 21108-2220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Siete 20a. Melhod of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MANOKIN PRESBYTERIAN CEM.6/22/99 PRINCESS ANNE, MD. Signature of Funeral Service Licensee 22. Name end Address of Fecility HINMAN FUNERAL HOME M00295 11673 SOMERSET AVE., PRINCES:
3a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. PRINCESS ANNE, MD. 21853 Approximate interval Between Onsel and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) a. ANOXIC ENCEPHALOPATHY 6 DAYS Examiner Due to (or as a consequence of) Examiner ASPIRATION-FOOD sician end buriel-transit Sequentially ilst conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burie Physician/Medical Due to (or as a consequence of) 98 980 23b. Did tobacco use contribute to the cause of death? detached Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 3 8 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? Completed completion of ceuse of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medicel examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 

Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No P funerel 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 28e. Date of injury (Month, Day Year) 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No 06-13-99 1700 ASPIRATION WHILE EATING DINNER 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b SALISBURY MD GOING NUTS CAFE edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and manner as stated. 2 W Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and piece, end due to the ceuse(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature end litie of certifier 29c. License number Julysely D.M.E. D0003599 06-20-1999 30. Name and address of person who completed cause of dealle (Item 23a) (Type, Print)

JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY MD 21801

3. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

JUN 2 2 1999

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Baltimore, Maryland 21215-0020

Box 68760.

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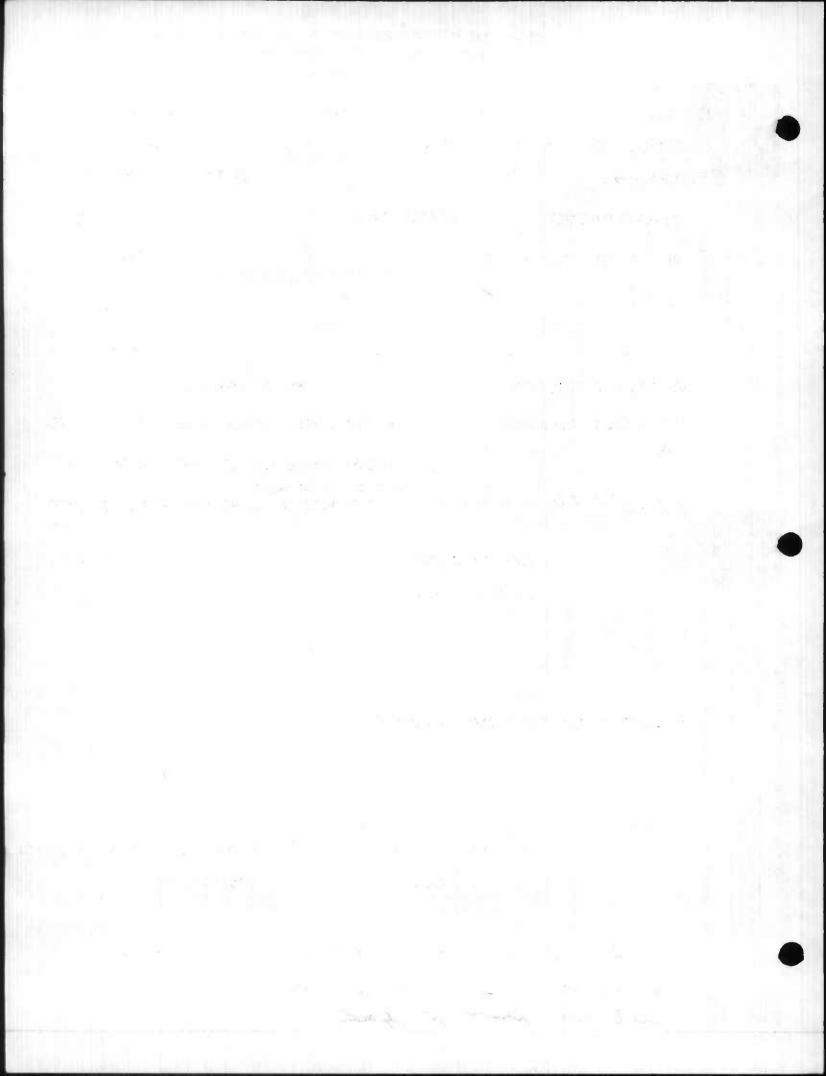
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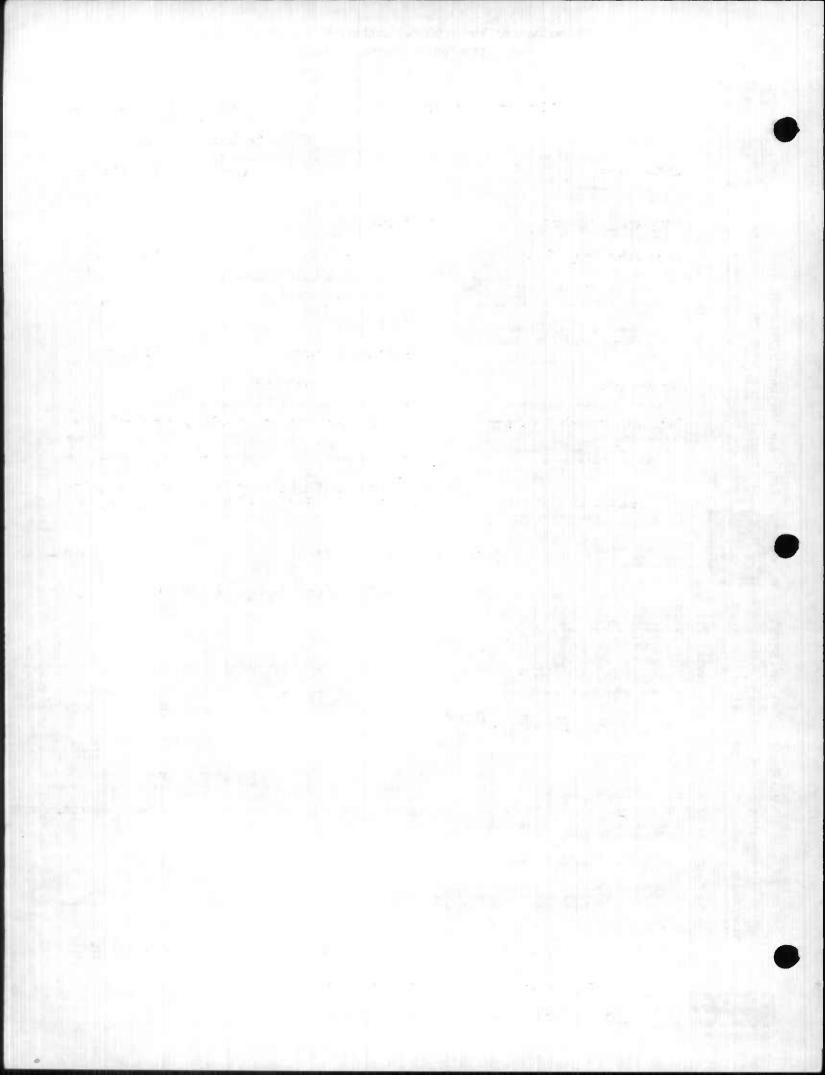
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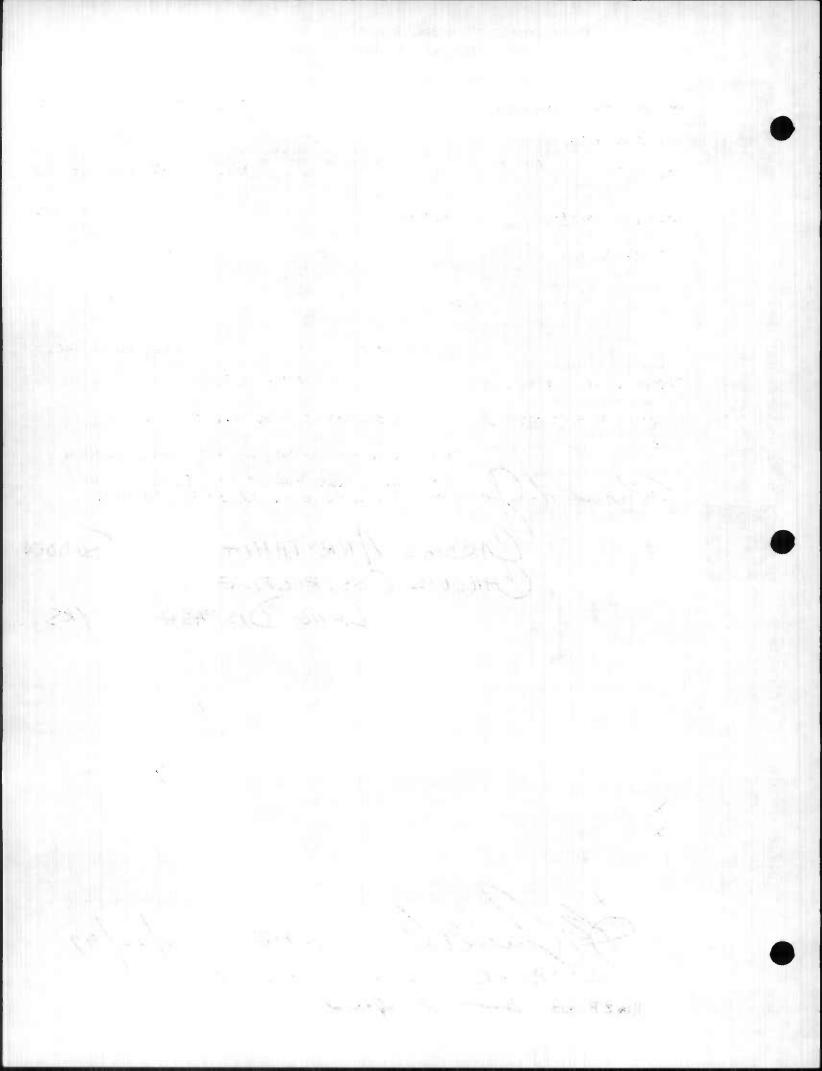
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Director	10e. Street and Number	ward			JOHUM	10f, Zip Code			10g. Citizen of	Whet Cou	ntrv?
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iner must Funeral	11. Maritel Status	12.1	Wes Deceder	nt Ever in U,S.	. 13. W		Hispenic Origin? (Stan, Mexicen, Puer	Specify Yes or No		ce - Americ	can Indian,
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o Be	George Orso						Christin	, ,			
T	19a. Informant's Name/Relation	nship (Type.	Print)		19b. Mailing	g Address (Stre	et and Number or F	-		n, State, Zij	o Code)
r trat	Patricia Rauso						og Place				
othe	20e. Method of Disposition			20b. Pla		sition (Name of natory or other p	2	Date	20c. Location		
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DHMH 16 Rev 6/95



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						epartment Certificate			R	eg. No.	2 6	. 1 0 9 7
Physici	an	Decedent's Name							2. Date of Dea Month	Day	Year	3. Time of Death
/Medic		George	0. Bi	llings					June	26 1	999	9:30 AM
Examin		4a Facility Name (If	not Institution, giv	e street and numbe	r)		- 1	4b. City, Town, or l	ocation of Death	4c. County		
	3	408 Schuc	ks Rd.					Bel Air		Har	ford	
Funeral		5. Social Security Nu			Age (In yrs. last birtl	Montha	Year Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthp	lace (State or Foreign
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of Health		20a. Method of Disp			cometen	Disposition (Name or oth	e of	ce)	Date	20c. Location	- City or To	wn, State
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or Attendi after death. Director: A	5	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined	28e. Place of t	njury - At homa, far	m, straat, factory.	office		28f. Location (5 City or Tow		ber or Rura	A Route Number,
2 # 2 =	Certification:	4   Homicide		building,	etc. (Specify)				City or row	ri, Siare)		
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Sta	te	31. Date filed (Month	h, Day, Year)	32. Regis	strar's Signaturg	nn stree		Baltimor	e, MU 21	201	_	



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Nama (First, Middla, Last) 2. Dete of Death Month **Physician** Irene Edna Boutchyard 21 1999 1:10 pm June /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3905 Somerset Court Havre de Grace Harford 9. Birthplece (State or Foreign Country) Virginia 5 Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 27, 1918 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□ M 21 F 168-14-3614 80 Yrs. Director Usual Residence of Decadent the Marylend 10d. fnside City Limits 10a State 10b. County 10c. City. Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner main to notified at 1X Yas 2 No Director Cecil Maryland Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? death with 21903 624 Richmond Street, P.O. Box 543 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedant Ever in U,S. Armed Forces? Was Decadant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, etc.) permit. Peges 1 and 2 should be filed within 72 hours effer c Department of Heelth and Mental Hygiene. Important: If them 27 is marked other than "natural", or frem any injury or other traumatic events. Black, White, atc. 1 ☐ Yes 2 No If Yes, Give Yaar or Datas: 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2X No Specify: Specify: White PV 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Eight Years Personal Residence Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fethar's Nama (First, Middla, Last) Charles M. Jennings Matilda Hampton 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Theresa I. Boutchyard (Granddaughter) 3905 Somerset Court, Havre de Grace, MD 21078 20b. Plece of Disposition (Name of cametery, crematory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stete Date Burial 2 Cramation 3 Removal from State Hopewell Cemetery 6/24/99 Port Deposit, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21 Signature of Funeral Service Licentine Lee A. Patterson & Son Funeral Home attensor, or Perryville, Maryland 21903-0188 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwaen Onset and Deeth **Physiclan** /Medical Immediate Cause (Final disaase or condition resulting in death) **Examiner** Examiner law requires that the death certificete be executed physician and s the buriel-trens Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disaase or Injury that initieted events resulting in death) Last Due to (or as e consequence of): Records, P.O. Box 68760 Physician/Medicai Due to (or es a consequenca of): 98 hed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed peen 1 ☐ Yes 2 No 1 □ Yas 2 □ No certificate Division of Vital Mospital or Attanding Physicien: 24 hours after death. Funeral Director: After this certifics 25. Wes case referred to medical exeminer? Be 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yas R No funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: ↑ Neturat 5 Pending 1 Tyes 2 No invastigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the ceuse(s) and manner es stated.

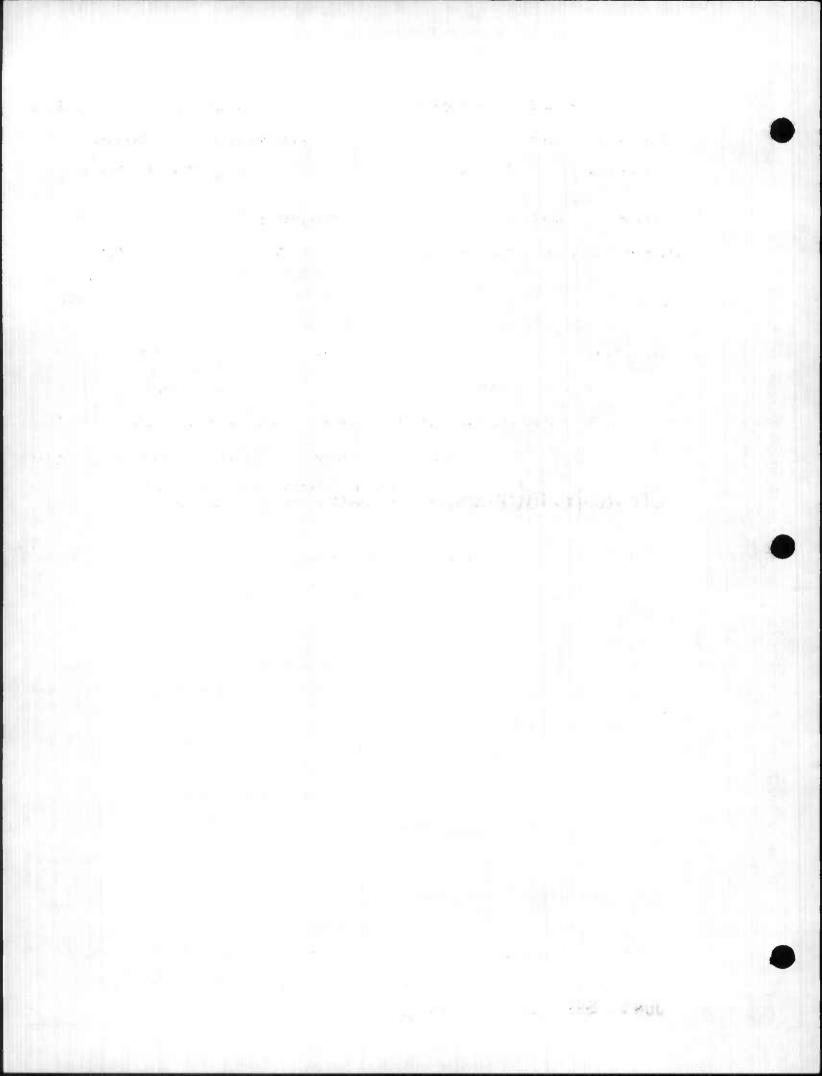
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) and menner stated. edicai 29e. Certifier To the I 29c. Licensa number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier P3227 JUNE 22 30. Nama and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 6,5 W. Machhai

Registrar

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32. Registrer's Signature

/ Road, Bel Air, Maryland



Drwun

1. Decedent's Neme (First, Middle, Lest)

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

of M	laryland /	Department	of	Health	and	Mental	Hygi	en
		Certificate	0	f Death	7		Pa	a N

**Physician** /Medicai Examiner 2. Date of Deeth Month

28a-f show 5 items 23a

Baltimore, Maryland 21215-0020

Box 68760.

Records. P.O.

Division of Vital

**Physician** /Medical Examiner

for usa or Attending Physician: After filled in by the Hospital

10:35 pm Lillian Mal Carroll 6 4e. Fecility Neme (If not institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Deeth Chestertown Kent Chestertown Nursing & Rehab. Center Hours Min. November 15, 1905 Smyrma, Delaware 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex 1 ☐ M 2 X F 9. Birthplece (State or Foreign **Funeral** Deys 93 Yrs. Director 214-30-9116 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at ty Yes 2□No Director Kent Maryland Chestertown 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? Morgnec Village Apt. 8A 21620 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married I ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: natural, or 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill ment of Health and Mental Hyant: If item 27 is marked oth jury or other traumatic even John S. Darrell Unknown 19e. Informent's Name/Retetionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 326 Third Street, Crumpton, Maryland 21620 Frances Wersten/Daughter 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) 6/16/99 Crumpton, Maryland Crumpton Cemetery 22. Name and Address of Feellity Fellows, Helfenbein & Newnam Funeral Home, P.A. 21. Signeture of Funeral Service Licensee 130 Speer Road, Chestertown, Maryland 21620 23e. Pert1. Enter y disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or helior failure. List only one cause on each line. Immediate Cause (Final 3 wonths disease or condition resulting in death) Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last Repression

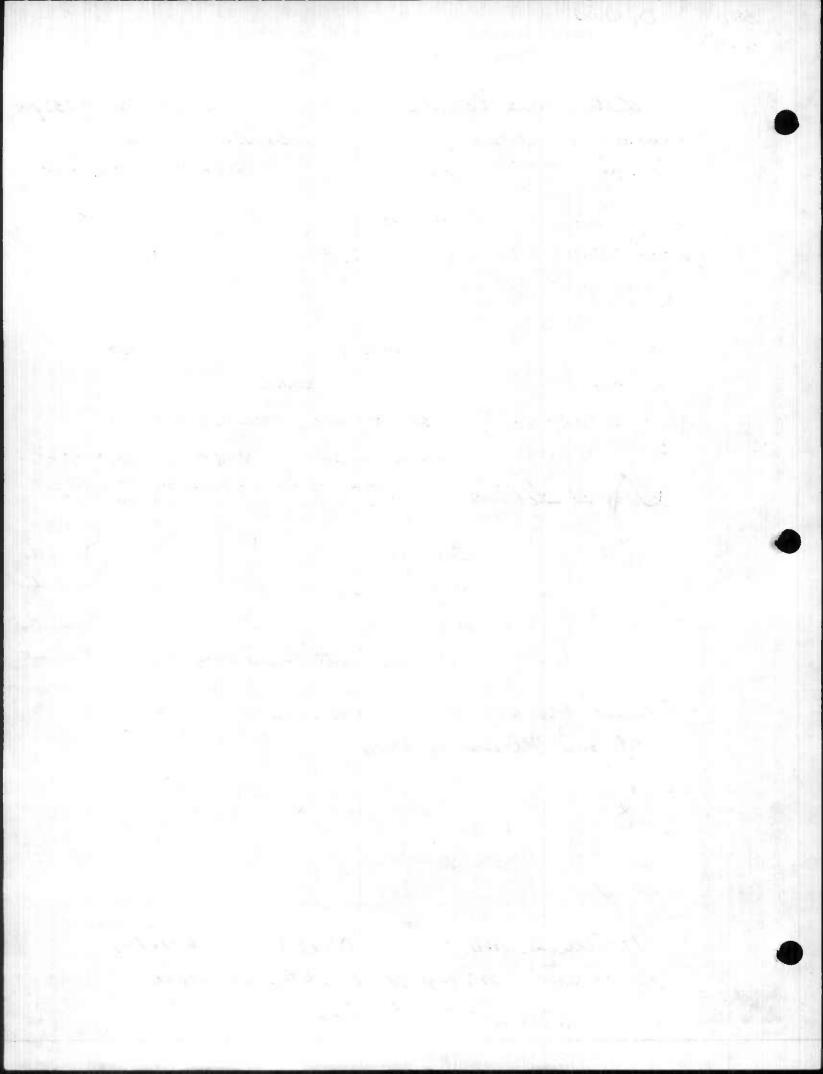
Due to for as a consequence of): Completed by Physician/Medical age with Recent Obly doctine Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uee contributs to the cause of death? Recent left Hip Fracture @ anemie 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Chronic Allresses & ASHD 24b. Were eutopsy findings aveileble prior to completion of cause of death? 24e. Wes an eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was cese referred to medicat exeminer? 28. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturel 5 Pending 24 hours after death. 2 Accident Investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Sulcide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end manner stated. 29e. Certifier Medical (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 164. Ulun MD. 6/14/99 1)21313 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) 223 High St., Chestatown MD 21620

32. Registrer's Signeture

State Registrar

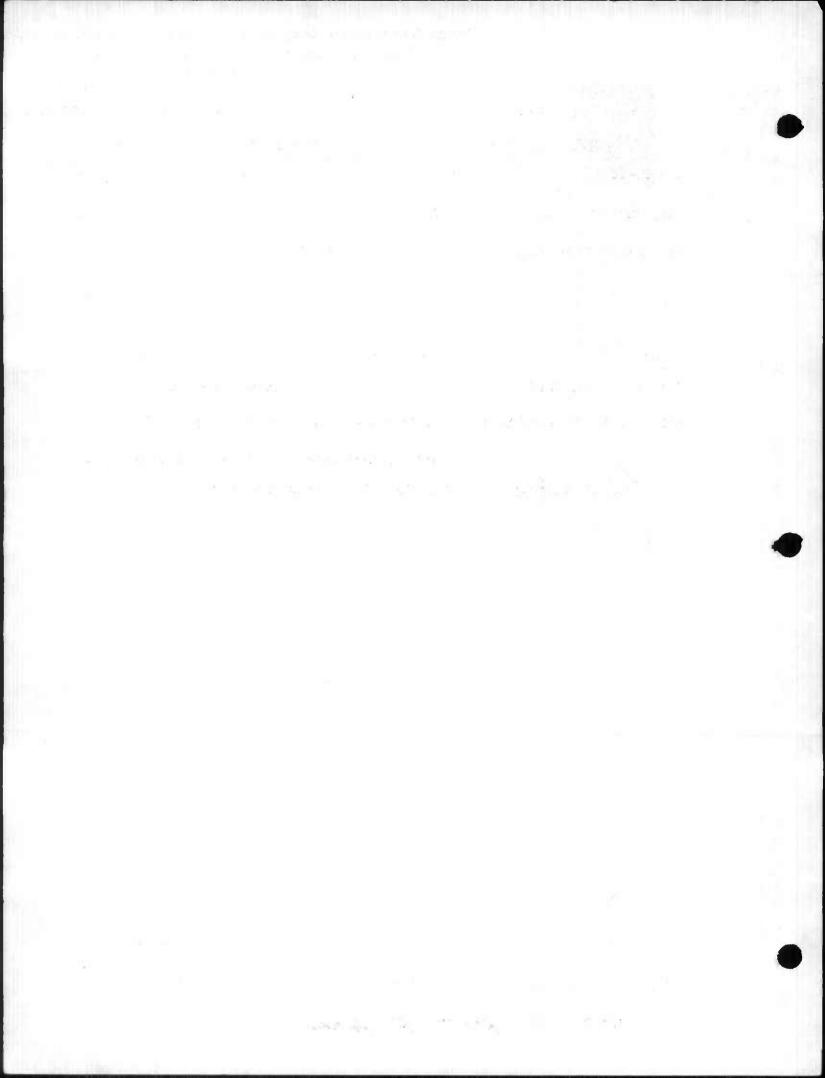
31. Dete filed (Month, Day, Year)



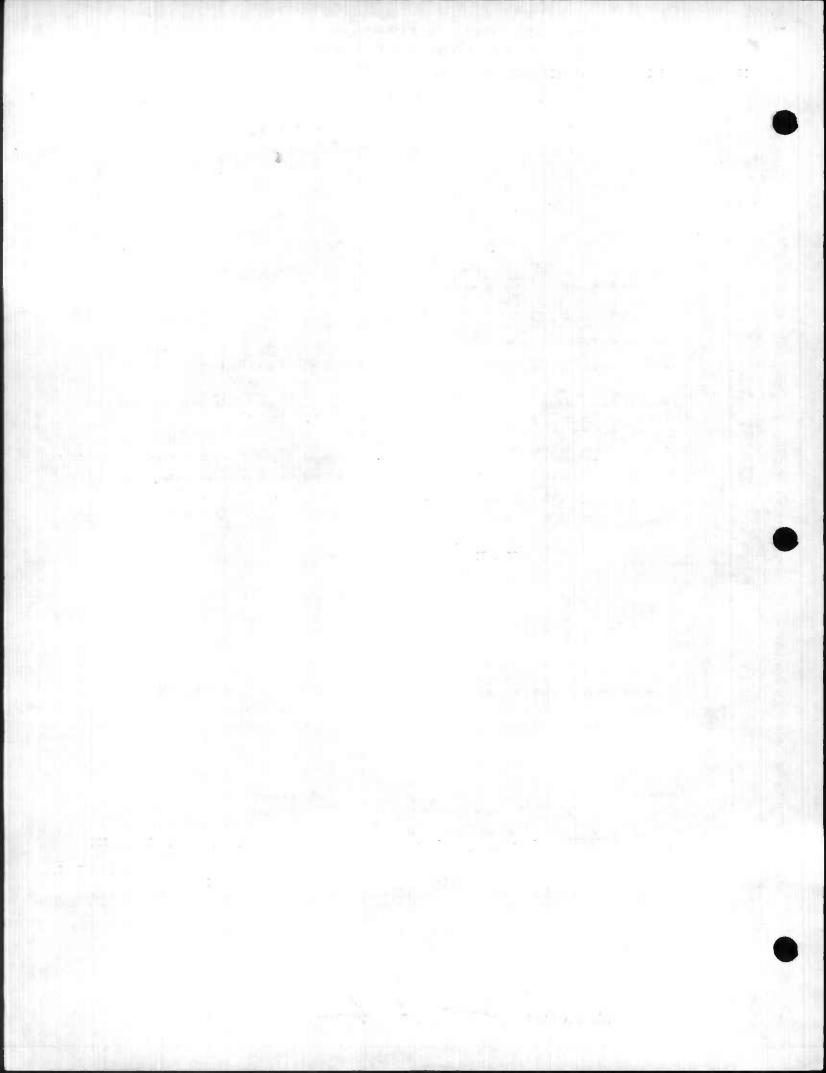
State of Maryland / Department of Health and Mental Hygiene

						Cert	ificate of	Death			Reg. No.	10	610	90
	Dhuala		1. Decedent's Name (First, Middle, La	est)			11		2.	Dete of De		Year	3. Time	of Death
	Physic /Medi		Helen L.	Clough						_	15, 19		3:30	0 a.m.
	Exami		4e. Facility Name (If not institution, gi					4b. City, Town,	or Locat	tion of Deat	h 4c. Co	unty of Deat	h	
			Edw. W. McCready					Crisfi				merse	t	
	Funeral Director		214-28-3051	Sex 7. Age 1□M 2⊠F	71	Yrs.	If Under 1 Year Months Days		Hrs. 8. Jin.	Dete of Bi (Month, De 1ay 7	th Year) 1928	Co	hplace (State ountry) Yland	or Foreign
	and **		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Loca	ition						10d. Inside	City Limits
	he Mary 28a-f eho	ector	Maryland Somer	set	Cr	isfie					10 011		1 <b>⊠</b> Ye	s 2 No
	23a or 2	Funeral Director	10e. Street end Number 290 Somers Cove	Apts.			10f. Zip Code 2	1817			-	U.S.A.		
020	s 1 end 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be nortified at	þ	11. Maritel Status  1 □ Never Married 2 □ Merried  3 ☎ Widowed 4 □ Divorced	12. Was Decedent II Armed Forces? 1  Yes 2 XN If Yes, Give Yeer or Detes:		lf Y	as Decedent of I fes, specify Cub ☐ Yes 2 ANo	en, Mexican, Pi	? (Specif uerto Ric	y Yes or No can, etc.)		Race - Ame Black, White ecify: W		
5-0	72 h	etec	15. Decedent's E	ducetion ade completed)	160	(Give kil	nt's Usual Occu	during most of	workina		16b. Kind	of Business/l	Industry	
2121	iene. than	Completed	Elementery/Secondary (0-12) Grade 7	College (1-4or 5		'life. DO Homem	NOT use retire	od)			At.	Home		
P	Hyg Hyg	BeC	17. Father's Neme (First, Middle, Last	')				18. Mother's	Name (F	First, Middle				
lar	should be filed with nd Mental Hygiene, i marked other than umatic event, the	ToB	Charles Upshur S	wift				E1	izak	eth F	Harris	on		
Maryland 21215-0020	1 end 2 short Health and A sem 27 is maintent		19a. Informent's Name/Relationship Hilda M. Swift (			_	Address (Stree					own, Stete, 2 1817	'ip Code)	
Baltimore,	parmit. Peges 1 en Department of Heal Important: if item 2 any Injury or other once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		cemet	ery, crema	tion (Name of tory or other pla Church O	,		Date 18/99		ion - City or i		
Balt	parmit. Departn Importa any Inju		21. Signature of Grandi Service Lice Robert H. Br	adshaw, Jr	A	Bra	Name end Address	Sons F				21.01	7	77.774.074,
			23a. Pert1. Enter the disease, or con	plicetions that ceused	the deeth. Do		W. Mai					2181	Approxim	ete
	Physician /Medical Examiner		shock, or heart feilure. List only Immediate Cause (Final disease or condition resulting in death)	θ	A	SCV							Interval B Onset and	etween d Death
		ner			Due to (or as a	conseque	ence or);							
60,	certificate be executed ding physician and use as the buriel-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initieted events	b	Due to (or es a	a conseque	ence of):			_				
ox 68760,	death certificete attending physi d for use as the	√Medicai	that initiated events resulting in death) Last	d	Due to (or as a	conseque	ence of):							
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o.	the cache	hys	Part II. Other eignificant conditions	contributing to death bu	it not resulting	in the und	eriying cause gi	ven in Pert I.			Yes 2 1		to the cause robably 4[	
ď.	es thet the death igned by the atte be detached for	by P	DVT								100 19		obday 4	
Records,	ew requir	Completed							_		en eutopsy ormed?		Were autops: evaileble prio completion of of deeth?	or to
	iclan: The lev certificate has rector, page 2	mo:								10	Yes 2 1	lo	1 □ Yes 2	□ No
Ita	ysician: The la is certificate ha director, page	Be	25. Wes case referred to medical examiner?					26. Place of	Death (0	Check only	one)			
>	hysic his ce il dire	은	1 ☐ Yes 25 No	Hospitel: 1 Mnpatie		Outpatient	3□ DOA Ot	her: 4 Nursin	ng Home	5 🗆 Res	idence 6 [	Other (Spe	cify)	
Division of Vital	Attending Ph or death. ector: After th by the funeral	Certification:	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation		y Year) 28b.	Time of Injury	M 1 [	nyat nrk? ]Yes 2 ☐ No	280	d. Describe	how injury o	ccurred		
D	tal or Att rs after d al Direct led in by	Certifi	3 Suicide 6 Could not be determined		iry - At home, i :. (Specify)	ferm, stree	t, factory, office		28f		(Street end N wn, Stete)	u <i>mb</i> er or Ru	urel Route Nu	ım <i>ber</i> ,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edicai	29a. Certifier (Check only one)  Certifying Pl 2 Medical Example	nysicien: To the best of miner: On the basis of and manner sta	examination a	ge, death o ind/or inve	ccurred at the ti stigetion, In my	me, date and pl oplnion, death o	ace, and ccurred	d due to the at the time,	cause(s) an dete end pla	d manner es ace, and due	stated. to the ceuse	ə(s)
	To To t	Σ	29b. Signature and title of certifier	4			29c. Licen						h, Day, Year)	1
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			30. Name and eddress of person who Dr. Vijay Karun				,	Crisfie	1d,	Md. 2	21817			
	Sta Registr		31. Date filed (Month, Day, Year)		r's Signature	4	lan	1.1						

DHMH 16 Rav 6/95



in al	Decedent's Name (F		USTIN	CL	1-99 WR AY	CROWE	LL			2. Date of De Month JUNE	20, Day 199	9 Year	3. Time of Death 1952 PM
4a	Facility Name (# no DORCHESTE	ot institution. R GEN	, give street ar ERAL HO	nd number SPIT	ÄL			4b. City, Too CAMBI	wn, or Loc RIDGE	cation of Deat		y of Death HESTE	ER
	Social Security Num 219-53-98	325	6. Sey M 2		Age (In yrs.	last birthday) Yrs.	H Under 1 Year Months Days		24 Hrs. Min.	8. Date of Bir (Month, Da Jan . 2	1 1999	9. Birth	place (State or Foreign http:/ yland
	a. Stete 10	ob. County			10c. Cit	ty, Town or Lo						1.	10d. Inside City Limits
	MD		chester	`		Cam	bridge						Volves 2□No
10	e. Street and Numbe		Locust	St.			10f. Zip Code 21	613			10g. Citizen of	What Could	
11	. Marital Status  19 Never Married 3 Widowed 4		ied 1 []	Decedent ed Forces Yes 27 es, Give r or Dates	No		Wes Decedent of If Yes, specify Cu		gin? (Spe n, Puerto F	cify Yes or No Rican, etc.)		ace - Americ ack, White, iny: blac	
		only highes	's Education of grade completed Collection	eted) ege (1-4o	r 5+)	16a. Dece (Give life.	dent's Usual Occi kind of work done DO NOT use retir	pation during most ed)		ng	16b. Kind of I	Business/In	dustry
17	. Father's Name (Fire							18. Mothe			, Maiden Suma		
40	Ti Se. Informent's Neme	mmy	Lee		Spe	encer	ng Address (Stree	and Mont		resa	Ann		owell Code
	eresa Ann						) Locust						, (2008)
20	e. Method of Disposi	remation	3 □Removel	from Stet	1	Plece of Dispo cemetery, cres	osition (Name of matory or other pl	ace)		Dete	20c. Location		
-	4 □ Donetion 5 [	Other (Sp	pecify)				wn Cemet			-24-99			Maryland
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di	nmediete Cause (Fin sease or condition sulting in death)			FOCAT	ION	th Do not ent	ter the mode of dy	ring, such es	cardiec o	r respiretory a	rrest,	0 0 0 0 1 1	Approximete intervel Between Onset and Death
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Secretarian Per 25	equentially list condition sufficiently list condition sufficiently list condition any, leading to imme suse. Enter Underly lause. Clisease or injust initieted events sufficiently list initieted events sufficiently list initieted events.  The condition of the c	itions, ediate ing ury st	a. SUF  b c	to death	Due to (c  Due to (c  Due to (c  but not res  tient 2\( \hat{Z} \)	or es a consec or as a consec or es a consec sulting in the u	quence of):	26. Piace ther: 4 Nu	a of Death	23b. Dld 1 □ 24a. Was perfe 1 □ 1 □ 1 (Check only) me 5 □ Resi 28d. Describe	tobacco use c Yas 2 No s an autopsy ormed? Yes 2 No one) idence 8 0 how injury occur	24b. Wash	o the cause of death  o the cause of death  beby 4 Tunknov  vere autopsy tindings valiable prior to pumpletion of cause death?
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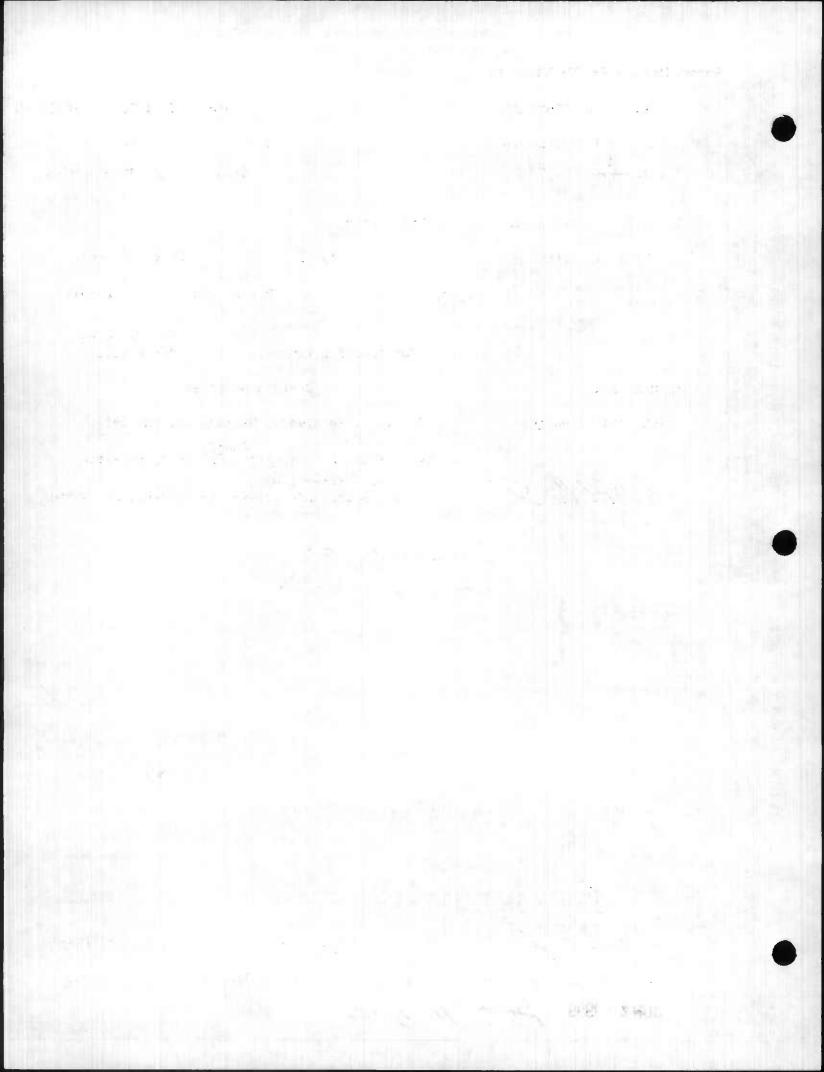
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Amended Item#5 perFH G773 7/15/99 EW 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** LUIS CRUZ-GONZALEZ 22 1999 10:30 AM June /Medical 4a Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Laurelwood Nursing Center E1kton Cecil If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Undar 1 Yaar Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** 1⊠M 2□ F Months Days Yrs. 78 Director 214-32-5449 August 24, 1920 Puerto Rico Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, tre Medical Examiner mant be notified at 1 Yes 2 □ No Directo New Castle Wilmington Delaware 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 217 Virginia Avenue 19805 United States Funeral death 12. Was Decedent Evar in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give US Army Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - American Indian, Black, White, etc. 11, Marital Status permit. Pages 1 and 2 should be filed within 72 hours after begarment of Haaith and Mental Hygiene. Important: if item 27 is marked other than "natural", or iter any injury or other traumetic event, the Medical Examinat 1 Never Married 2 Married 1₺ Yes 2□ No Specify: Puerto Rican Specity: Hispanic þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) New Building Elementery/Secondary (0-12) College (1-4or 5+) Construction Laborer Construction 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Father's Name (First, Middle, Last) Manuel Cruz Beatriz Gonzalez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edith Prado / Daughter 217 Virginia Avenue, Wilmington, DE 19805 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) Date 20c. Location - City or Town, State June 25 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Delaware Veterans Cemetery 1999 Bear, Delaware 22. Name and Address of Facility Crouch Funeral Home 21. Signature of Funeral Service Lic 127 South Main Street, North East, MD 21901 cure 23a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failura. List only ona ceuse on each line. Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Causa (Final Cereb-osasev/a disaase or condition resulting in death) **Examiner** Due to (or as a consequenca of): Examiner ANOX. c enuglipe. physician and s the burial-transit the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Dua to (or as a consequence of): esn 23b. Did tobacco use contribute to the cause of death? Part II. Other elgnificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. P.0. signed by t 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to 24a. Was en eutopsy Completed complation of causa of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 this 28a. Date of Injury (Month, Day Year) funeral 28d. Describe how Injury occurred 27. Manger of Death 28b. Time of 28c. Injury at Work? Certification: or Attending Patter death.

Director: After After 5 Pending Investigation 1 Neturel 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. Medical To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of confrig 29c. Licensa number June 22, 1999 30. Name and address of parson who completed cause of daath (Item 23a) (Type, Print) 5+/VA 3 mauldin Ave. Northeast, mD 21901 homas Finucan mo 32. Registrar's Signature 31. Date filed (Month, Day, Year)

JUN 2 4 1999 State Registrar

**DHMH 16 Rev 6/95** 



Physician	Decedent'a Name (First, Michael Control of the	dale, Last)						2. Dete of Dea Month	ath Day	Yeer	3. Time of Deeth
/Medical	HENRY BOY		ORDER					June	23 1	999	3:35 AM
Examiner	4a Facility Name (If not institut		end number)			4	lb. City, Town, or L		1		
	65 Bouchelle				hday) If Under	1 Voor	North			cil	
Funeral Director	5. Sociei Security Number  231-12-7876  Usuel Residence of Decedent	6. Sex 1 1 M 2		In yrs. lest birti	Months Months		Hours Min.	8. Dete of Birt (Month, Da) July 25	y, Year) 5, 1920	9. Birthp Coun Vir	elece (Stete or Foreign stry) ginia
the tale	10a. State 10b. Cour	nty	11	0c. City, Town	or Location					1	0d. Inside City Limits
she was	Maryland Co	ecil_			North E	ast					1 ☐ Yes 2 ☒ No
or 28e-f be notified Director	10e. Street and Number				10f. Zip	Code			10g. Citizen of W	/hat Coun	ntry?
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72 hours after death with the Maryta natural, or thems 23e or 28e-f shoo dical Examiner must be notified at sted by Furneral Director	11. Meritel Stetus  1 Never Merried 2 M  3 Widowed 4 Divorce	Ace	es Decedent Ever med Forces? Yes 2 No Yes, Give US per or Detes: W		If Yes, spec	cify Cube	lispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)	Blac	k, White,	etc.
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marks marks marks	Raymond Corde		dma)	104	Mailine Address	/Ctennet	Minerva and Number or Ru	a Holbro		Ctata 7im	Cadal
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Physician	Shoot, or hour tonors.										Onset and Death
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 0705 1999 June 20 LYNN ELEANOR CUMBIE /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Fallston Fallston General Hospital Harford 8. Date of Birth (Month, Day, Year) Jan. 12, 1953 If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Months Devs 212-62-6905 46 Maryland Director Usual Residenca of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. toside City Limits r than "naturel", or items 23s or 28s-f show the Madical Expression than the notified at 1 ☐ Yes 25No Director Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 21040 USA 1902 Larch Court Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ᠌ No It Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after in ent of Health and Mental Hyglene. Int: If Hem 27 is marked other than "naturel", or ite 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: à White 3 Widowed 450 Divorcad Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Eiementary/Secondary (0-12) College (1-4or 5+) Office Administrator Civil Engineering 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Thelma Hasselbarth Edwin Arthur Sofsky Margaret 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1902 Larch Court, Edgewood, Maryland Nicholas P. Cumbie - Son other 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 6 1 D Burial 22 Cremation permit. Page Department of Important: If any injury or 5 Other (S 4 Donat 6-26-99 Towson, Maryland Hilltop Service Corp. Funeral Service 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD

The Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. **Physician** BREAST CANCER /Medical Immediate Ceuse (Final YEARS METASTATIC diseese or condition resulting in death) Examiner Due to (or as a consequence ot): Examiner the burial-transit and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) attending physician Physician/Medical Due to (or as a consequenca ot) 5 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the signed by t 1 Yee 2 No 3 Probably 4 Unknown SEPSIS à 24b. Were autopsy tindings available prior to 24e. Was an eutopsy Completed peen s completion of cause of death? 1□ Yes 2□ No 1 ☐ Yes 2 ☐ No certificata the funeral director, Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA this 27. Menner of Death Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 5 Pending Investigation 1 Natural 1 Yes 2 No To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. edical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of conflict 29c\_License number my 10 BELAIR ROAD played cause of death (Item 23a) (Type, Print) ALLSTON

82. Registrar's Signetur

Registrar

State

Cumbie, Lynn Eleanor

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State of Maryland / Department of Health and Mental Hygiene

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	Carrie Melind	a Cu	llev							June	20	Yaar 1999	2115	
lical iner	4a Facility Nama (If not Institu			per)				4b. City	, Town, or L	ocation of Death			2113	
IIICI	Harford Memo	rial	Hospita					Нам	ab as	Grace	Harf	ord		
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at yilding XIX 13-0020 should be filed within 72 hours after death with the Maryland of Mantal Hygiens. marked other than "natural", or items 23s or 23s-1 show matic event.		by runeral Director	11. Maritel Stetus  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates:			Vas Decedent of I Yes, specify Cub	Hispenic Orlgin? (Sean, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)	Speci	ca - Americ ock, White, fy: Wh	
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To the Hospital or Attending Is within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	) ionipo		(Uneck only 21 Medical Exam	sicien: To the best of e	xamination	dge, death and/or inv	occurred et the ti	me, date end pleca opinion, deeth occu	a, end due to the	ceuse(s) and m	enner as st	eted. the cause(s)
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20			30. Neme and address of person who c		th (Item 22	a) (Tuno I	-	7 (3)		0 0	70	( )
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	State		31. Date filed (Month, Day, Year)	32. Registrer			1					- 1

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician JUNE 13, 1999 CHARLES HENRY DIEFENDERFER 7:27 AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 3998 OCEAN GATEWAY TRAPPE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2□ F Months Yrs. Director 219-14-3174 DEC. 19,1924 MARYLAND Usual Residence of Decedent with the Meryland 10a State 10b, County 10c, City, Town or Location 10d. Insida City Limits r than "natural", or items 23a or 28a-f ahow the Medical Examiner reset be notified at MD 1 Yes 2 No TALBOT TRAPPE Director 10f. Ztp Code 10g. Citizen of What Country? 10e. Street and Number 3998 OCEAN GATEWAY 21673 USA Funeral death 12. Was Decedant Evar in U,S. Armed Forces? 1 (X) Yes 2 □ No tf Yes, Give Year or Dates: WW I I 14. Race - American Indian. Was Decedent of Hispanto Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours efter 1 ☐ Never Married 2 N Married Maryland 21215-0020 1 Yes XXNo Specify: WHITE à 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) al Hygiene. Elamantary/Secondary (0-12) Coliaga (1-4or 5+) EQUIPMENT OPERATOR 11 STATE HIGHWAY ADM. -0traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 12 should be finend the new Mental Finend Mental Finend Mental Finend of Finend HENRY EARL DIEFENDERFER EDNA ELIZABETH GRIFFIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Pages 1 and 2 sinent of Heelth en SHIRLEY P. DIEFENDERFER/ WIFE P.O. BOX 43, TRAPPE, MD 21673 other t altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ò permit. Page Department of Important: If any Injury or WHITE MARSH CEMETERY 6-16-99 TRAPPE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Sign ture of Funeral Sarrice Licensee uny FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. FSI 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 100 an **Examiner** Dua to (or as a consequence of): Examiner certificate be executed valcian end Sequantiatly list conditions, if any, leading to immediate ceusa. Enter Underlying Causa (Disaase or Injury that hittated avents resulting in daath) Last Dua to (or as a consequence of): Box 68760. physician Physician/Medicai the Due to (or as a consequence of): 9 esn 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. deteched the 1 Yes 2 No 3 Probably 4 Unknown à disense þ Records, 8 24b. Were autopsy findings available prior to 24a. Was an autopsy Completed completion of cause of death? page 2 s hes 1 Yes 2DINO 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Was cese rafarred to medical axaminar? Be 26. Place of Death (Check only ona) Hospitat: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Deacribe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural efter death. Director: Aft 1 Yas 2 No 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 Homicida 24 hours Hospital 29a, Cartifiar 🖎 Certifying Physician: To the bast of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and manner as stated. within 24 hor To the Fune completely fi edicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and ptace, and due to the ceuse(s) and manner stated. 4 29b. Signature and title of good 29c. License number 29d. Date signed (Month, Day, Year) 0 D39749 30. Name and addrass of person who completed ceuse of death (ttern 23a) (Type, Print) DAVID G. OLIVER, M.D., 503 DUTCHMAN'S LANE, EASTON, MD 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 1 4 1999

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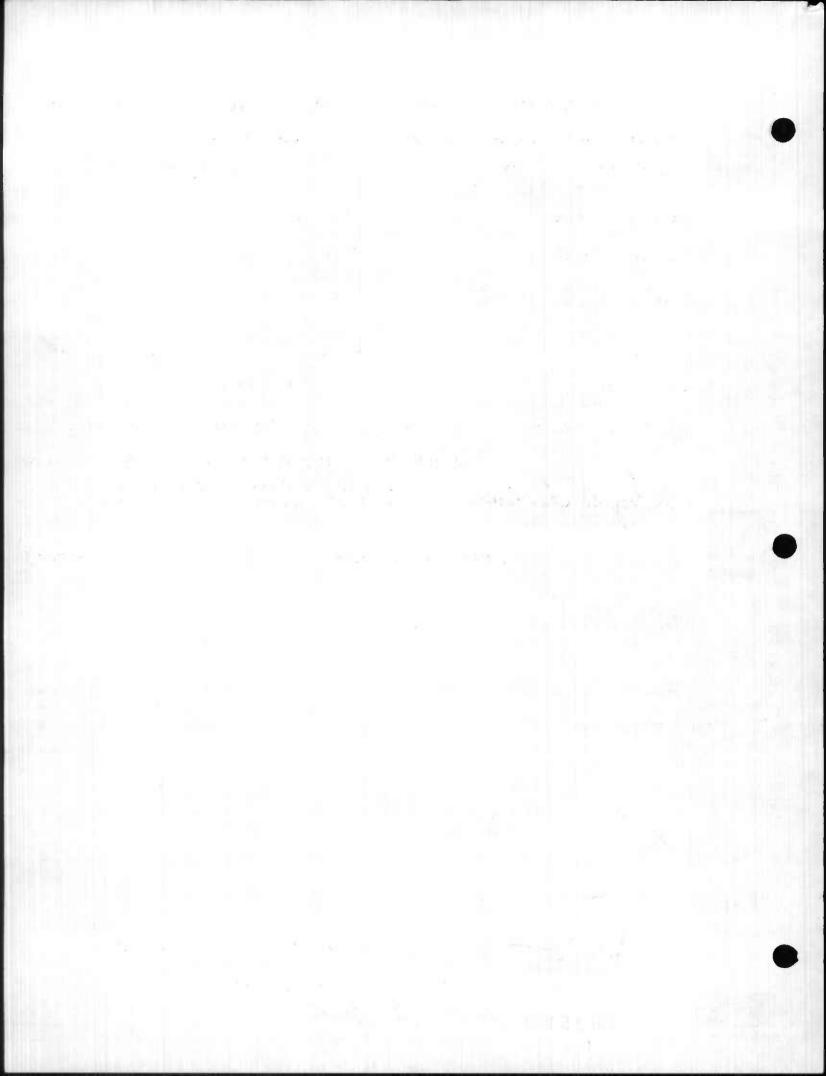
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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Otate of	wiai yiai		rtificate of	Death		Reg. No.		1000
	Physici	an	Decedent's Name (First, Mid     Geo.)				Elsie	Do	nbv	2. Date of De		Year 999	3. Tima of Death
9	/Medic			geia			EISIE	Dei	nby	June			1425
	Examin	er	4a Facility Name (If not institute The Kent and				ital,	Inc.	4b. City, Town, or I		4c. County Ker		
	Funeral Director		5. Social Sacurity Number 221-14-4750	6. Set	х Эм 2 <b>Д</b> ЖF 7.	Aga (In yrs. 77	last birthday) Yrs.	If Under 1 Yaar Months Days		8. Date of Bird (Month, De Feb. 8	, 1922	9. Birthe Cour Potts	place (State or Foreign offny) Stown, MD
	fand m		Usual Rasidence of Decedent  10a. Stata 10b. Coun	y		10c. Cit	ty, Town or Lo	ocation	-			1	0d. Inside City Limits
	e Mery	ctor	Maryland 1	Kent				Mill:	ington				NOXYes 2 □ No
	or 28	Funeral Director	10e. Street and Number					10f. Zip Code	1		10g. Citizen of V		ntry?
	a 23s	erai	312 Crane Stree		12. Was Decede	ent Ever in II	S 13	2165		pecify Yes or No	U.S		ean Indian,
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Menyland Depertment of Heelth end Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-1 ahow any Injury or other traumatic event, the Wedical Examiner must be notified at ange.		1 Nevar Marriad 2 Ma	rried	Armed Force 1 ☐ Yes 2 If Yas, Give Yaar or Date	es? OXNo		If Yes, specify Cut  1 ☐ Yas 2 ☐ No	Hispanic Origin? (S ean, Maxicen, Puert Specify:	o Ricen, atc.)	Specify Specify	k, White,	
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Ilan	Aental Aental rked c	ToB	Asbury Hicks						Emma Go	ldberg			
ary	s man		19a. Informant's Name/Raiatio	nship (Ty	rpe, Print)		19b. Maili	ng Addrass (Stree	t end Number or Ru	ral Route Numb	er, City or Town,	State, Zip	Code)
S 6	m 27 I her tra		Mr. Garnett De	nby/	Son	100h I	204 L	incoln D	rive, Che	stertow	n, Maryl	and	21620
altimore,	If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cramation			ata	cemetery, cra	metory or other ple					
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e E	Depe Impo		Yary B.	Je	ellow	3	IPC	Box 270	, Milling	ton, Ma	ryland 2	al F 21651	
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68760,	sicien burie	calE	causa. Enter Undarlying Cause (Disease or Injury thet initiated events	₹⊸	c	Due to /s	or as e conse	ruence of):					
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	within To the	Me	29b. Signature and title of certif	iar					sa number		29d. Data signe		Dey, Year)
			) Sere	+				0	-138-24		6.23	55	
		5	30. Name and address of person										
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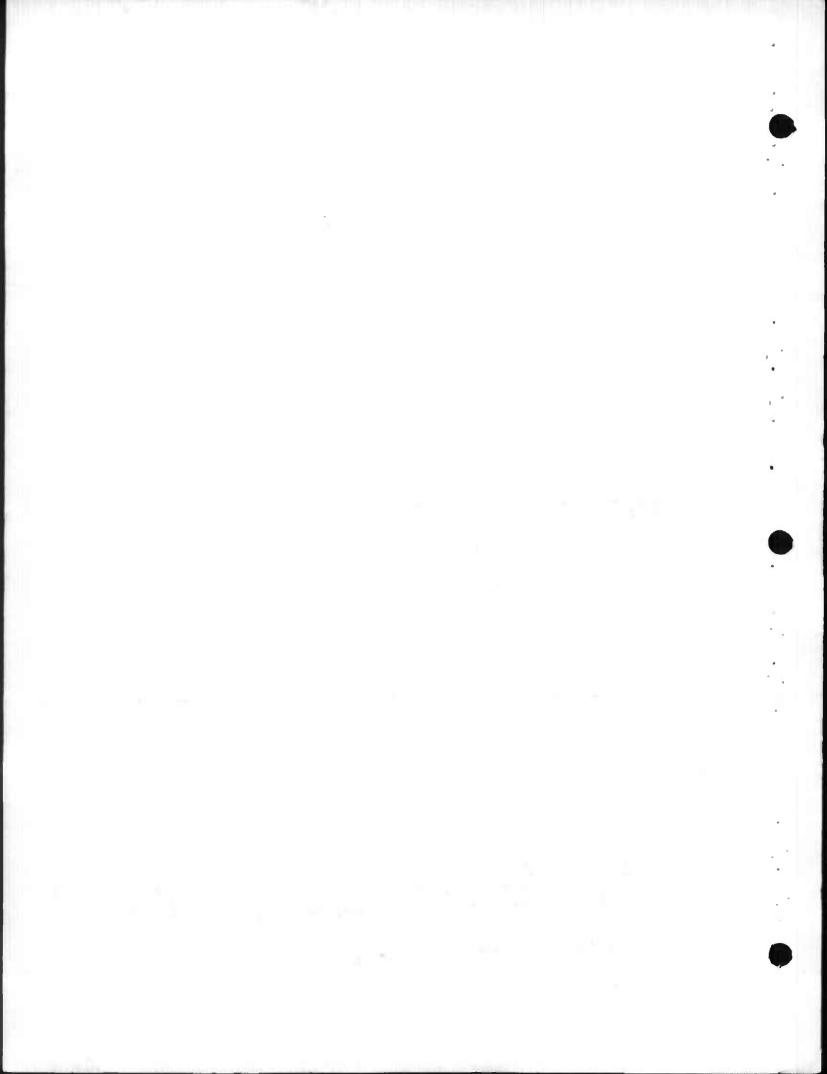
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospifal or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the afterding physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

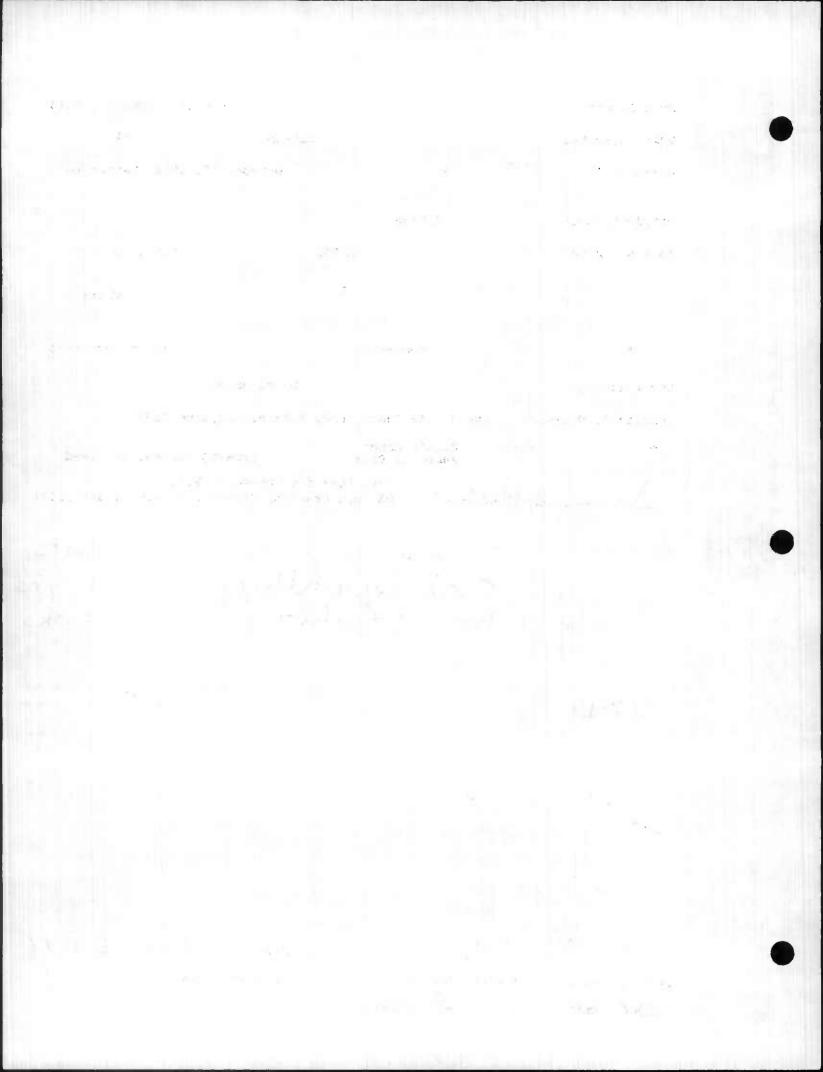
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTA	L HYGIENE
CERTIFICATE OF DEATH	BEG NO

1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO.											
- 1	1. DECEDENT'S NAME (First, Middle, Last)							3. TIME OF DEATH			
	Frederick Milton	Davis			June 28	4:00 AM					
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In	yrs. last birthday) F	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH 8. BIRTHPLACE (State or Formion					
	215-12-7851										
	Se. FACILITY NAME (If not institution, give a	CITY, TOWN O	R LOCATION OF DE		9c. COUNTY OF DEATN						
S I	4325 Main St. Lineboro Carrol										
ង្គ	RESIDENCE OF DECEDENT  10a. STATE  10b. COUNTY						0022				
DIRECTOR		rroll		eboro	ION			10d. INSIDE CITY LIMITS?			
	10e. STREET AND NUMBER				ZIP CODE			1 X YES 2 NO			
FUNERAL	4325 Main Street			101.	21088	-	WHAT COUNTRY?				
<u> ۲</u>	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARM			13. WAS DEC		IIC ORIGIN? (Specify Yes	CE - American Indian.				
	1 Never Married 2 Married	2 NO	If yes, spe	city Cuban, Mexica	n, Puerto Rican, etc.)	ck, White, etc.					
B⊀	3 Widowed 4 Divorced			, , , , ,	ZZEJ NO Opecny		WILL DE				
COMPLETED	15. DECEDENT'S EDU- (Specify only highest grade	16a. DECEDENT'S USL (Give kind of work	JAL OCCUPATIO	N et of working	16b, KIND OF BUSI						
ا بر	Elementary/Secondary (0-12)	ille. Do NOT use re	tired.)		Funnita	afacturing					
₹		Cabinet	Maker			iracturing					
	17. FATHER'S NAME (First, Middle, Last) Frederick Davis				ME (First, Middle, Maiden S	umame)					
BE	19a. INFORMANT'S NAME (Type/Print)		405 4441 440 40			e Tracey					
이	Monica V. Davis	/ Wife				neboro, MD		,			
- 1	20A, METHOD OF DISPOSITION	206 (					21088				
	1 🖄 Buriel 2 🗆 Cremation 3 🌣 Removal from State										
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY										
- 1	Geiple Funeral Home, Inc.										
				by I	dain St.	Glen Rock	c, PA 1	7327			
	23. PART I. Enter the diseases, or complications that caused tha death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, ahock, or heert feliure. List only one cause on each line.  Approximation interval Bellines.										
	iMMEDIATE CAUSE (Final disease or condition	mata	f. + (0	Par /	arciana	744 -		Onset and Death			
	MMEDIATE CAUSE (Final disease or condition resulting in death)  a. Due to form a A consequence of:										
z I	Colen Carcinoma										
CERTIFICATION	Sequentially list conditions,  If any, leading to immediate  DUE TO (OR AS A CONSEDUENCE OF):										
<u>ა</u>	Cause, Enter UNDERLYING CAUSE (Disease or Injury										
	that initiated events DUE TO (OR AS A CONSEDUENCE OF):  resulting in death) LAST										
5	d.										
AL.	PART ii. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY 24b. W										
	NEASTIES MELLITUS							AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
MEDIC											
	1   YES 2   NO 2										
HYSICIAN:	25. WAS CASE REFERREO TO MEDICAL  EXAMINER?  MOSPUTAL:  ADDRESS: WAS CASE REFERREO TO MEDICAL  EXAMINER?										
Š	HOSPITAL: 1 VES 2 NO THER: 1 Inpetient 2 ER/Outpetlent 3 DOA 4 Nursing Home 6 Residence 6 Other (Specify)										
0.	27. MANNER OF DEATH  1 Natural 5 Pending	28s. DATE OF INJURY (Month, Day, Year)	28a. DATE OF INJURY (Month, Day, Year)  28b. TIME OF INJURY 28c. INJURY AT WORK?  M 1 YES 2 NO				20d. DESCRIBE HOW INJURY OCCURED				
B	2 Accident Investigation										
<u>۵</u>	3 Suicide 6 Could not be determined	building, etc. (Specif)	- At home, ferm, street, fectory, office			261. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
<u> </u>											
COMPLET	(Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
8	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.										
BE	29b. SIGNATURE AND TITLE OF CERTIFIED	9b. SIGNATURE AND TITLE OF CERTIFIER  29c. LICENSE NUMBER  29d. DATE SIGNED (Month, Day, Year)									
0	30 NAME AND ADROCCS OCCUPEDON MAN		. > June 28, 1999								
	CO LEN N F- LEISTER MD. 220 POTOMAC AVE HANOVER PA 1739/										
	31. DATE FILED WORN DAY 1999										



			State of Ma	arylan		artmen		lealth and M Death		giene Reg. No.	2	1360	
		Decedent's Name (First, Middla, Last)     Data of Death									Yaar	3. Tima of Death	
Physic /Med		June Drummonds									0915		
Exam		4a Facility Name (If not institution, give street and number)  4b. City, Town, or Lo											
		Union Hospital Elkton						Cecil					
Funera	1	Months Days Hours					If Undar 24 Hrs. Hours Min.	n. (Month, Day, Year) Country)					
Directo	r	408-50-3077	408-50-3077 1□M 2⊠F							1932	Tenne	ssee	
pue **		Usuel Rasidance of Decedant  10a. Stete 10b. County		10c. City, Town or Location							1	0d. Inside City Limits	
f sh	jo	Maryland Cogil		E.	lkton							1 Yas 2 No	
/z nous arter death with the maryend natural", or thema 23e or 28e-f show fical Examiner must be notified at sted by Funeral Director	190	Maryland Cecil Elkton  10e. Street and Number 10f. Zip Coda							10g. Citizan of What Country?				
	Ö	13 Peach Road				2	21921 Unite					tes	
	Jer	11. Maritel Stetus	12. Wes Dacedent	res Dacedent Evar in U,S. If Yas, specify Cu			dent of H	ispanic Origin? (Spe	14. Race - Amaricen Indian,				
	5	1 ☐ Naver Married 2 ☐ Married	Armed Forcas? 1 ☐ Yas 2 ☒ No			1 ☐ Yas 2 ₹ No Specify:					ck, White, atc.		
4	l by	3 ☐ Widowed 4 ☐ Divorced	If Yas, Giva Yaer or Datas:			2 1140	Specify.	Specify: White					
Hygiene.  Hygien	etec	15. Decedant's Education (Specify only highast grada complated)			16a. Decedant's Usual Occupation (Give kind of work dona during most of work)				ing 16b. Kind of Business/Industry				
	d d	Elemantary/Secondary (0-12) Collaga (1-4or 5+)				se retired	retired)				her own home		
1			12 Homemaker				18 Methods Name	/First Middle			n nome		
E STE	Be	17. Fathar's Nema (First, Middla, Last)								(First, Middla, Maidan Sumama)			
meric	10	Homer Mozingo  19a. Informant's Name/Ralationship (T.	ima Printl		10b Maili	an Address	/Street	Maude I and Number or Run		er City or Tour	State 7in	Code	
2.5		Charles E. Drummo		nd				, Elkton,			-	Coday	
H di		20a. Mathod of Disposition	onds/ nusbe	20b. P	Place of Dispo	sition (Nan	na of		Data	20c. Location -		own, Stete	
0 10		1 ☐ Surial 2 ☐ Cramation 3 ☐ I		Gif	pin Ma	natory or o	thar plac	(a)	105 100				
unfu.		4 Donation 5 Other (Specify,		Mem	orial		d Addre		/26/99	Elkton,	Mary	land	
any i		21. Signatura of Funeral Service Licensee  22. Nama and Address of Fecility  Hicks Home for Funerals, P.A.											
		Dormed	8- Hel	(new)				tockton S			aryla		
		23a. Part1. Entar tha disaasa, or comp shock, or haart failura. List only o	ona causa on aach li	the death	n. Do not en	ar tha moo	a or oryin	ig, such as cerdiac (	or raspiratory e	rrest,	1	Approximate Intarval Batween Onset end Death	
sician edical													
niner		Immediata Causa (Final disaasa or condition rasulting in death)  a. Preuvovic									IWK		
	<b>1</b> 5			Dua to (o	or as a consac	quance of):		11.				100.100	
sician end buriel-transit	Examiner		b	77C)	NOIL	MC	b.	NANI			t	10412	
niel-tr		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying									2 14.		
nysicia he bur	ca	Ceuse (Disease or Injury C.  Due to (or as a consequence of):											
	Ped	rasulting in death) Last											
or use	and		d										
igned by the attending price detached for use as the detached for use as the by Physician/Med	0	Part It. Other significant conditions contributing to death but not resulting in the undarlying ceusa givan in Part t.						23b. Did tobacco use contributa to the cause of death?					
etach	Phy	(00)					1 Yes 2010 3 Probably 4						
9	b							Ton West states					
should	Completed							performed? avail			ara autopsy findings allabla prior to implation of cause		
N	ple					_					of	death?	
30	00								10	Yas 2 No	10	☐ Yes 2☐ No	
5	Be (	25. Was cesa referred to medical     26. Place of Death (Check only one)								ona)			
Il director, pag	ို	1 Yas 2 No	Hospitat: 1 Inpatia	ant 2	ER/Outpetier			TINUISING NO	ma 5□Ras	dance 8 Oth	ar (Speci	(y)	
funeral									how injury occur	red			
the fu	Certification:	2 Accidant investigation M 1 Yas 2 No											
d in by the	E	3 ☐ Sulcida 6 ☐ Could not be datarmined	28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)  28f. Location (Streat and Number or Rural Route Number of City or Town, State)							al Routa Number,			
lled													
To the Funeral Director: completely filled in by the	edicai	29a. Certifier 12 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and due to the causa(s) and mannar as steted.  (Check only 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to the causa(s) and mannar as steted.											
omple mple	Me	one) and manner stated.  29b. Signature and title of certifie: 29c. License number					e number		29d. Data signe	d (Month,	Dav. Year)		
within 2 To the comple	_	* 1/1 A A A A A				230			June 26, 19				
		pre III	MAT	,			DI	44716		June	26	1777	
	- 1	30. Name and addrass of person who c				Print)							
	- 1	-1-L	111 774	TT 1	C+ma.	+ P	12+0	n Marula	nd 219	2.1			
L a	tate	Jose Ma M.D.	111 West			et, E		n, Maryla	nd 219	21			

State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** JUNE Edith Marie Deweese 02:30 Pm /Medical 4a Facility Nema (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 9. Birthplace (State or Foreign Country) Hayve de Grace If Under 24 Hrs. R Date Hartord 12ens lursing Home 8. Date of Birth (Month, Day, Year) If Linder 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1□M 2⊠F Country) Maryland 216-05-3154 Yrs. 80 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Maryland Cecil Perryville 1)CYes 2□No Director 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 208 Concord Apartments 21903 U.S.A. Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 72 hours after 1 X Wever Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2XXNo Specify: Specify: 2 White 3 Widowed 4 Divorced "natural". Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working tile. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within in Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n any Injury or other traumatic avair. Bata Shoe Company Elementery/Secondary (0-12) College (1-4or 5+) Belcamp, Maryland Nine Years Machine Operator 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Charles J. Deweese Florence Harris 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William W. Deweese (son) 1531 Greenspring Avenue, Perryville, Maryland 21903 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete Naurial 2 ☐ Cremetion 3 ☐ Removel from State Hopewell Cemetery 6/27/99 Port Deposit, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Neme and Address of Facility Lee A. Patterson & Son Funeral Home MALITERA 21903-0188 Perryville, Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner ician and burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician sthe burial P.O. Box 68760 Physician/Medical Due to (or as a consequence of): 980 Part II. Other significant 23b. Dtd tobacco use contribute to the cause of death? regnations contributing to death but not resulting in the underlying cause given in Pert I. 1 Yaa 2 No 3 Probably 4 Unknown by Sign d be 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy performed? has 1 Yes 2 No 1 ☐ Yes 2 NO funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Seturing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 €10 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Deat 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attandit within 24 hours after death.

To the Funeral Director: A completely filled in by the fi death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 ☐ Medical Examiner: On the basis of exa and manner steted. (Check only one) nination and/or investigation, in my opinion, death occurred et the time, date end pleca, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) tress of person who or use of death (Item 23a) (Type, Print) FIM 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State JUN 2 8 1999 Registrar

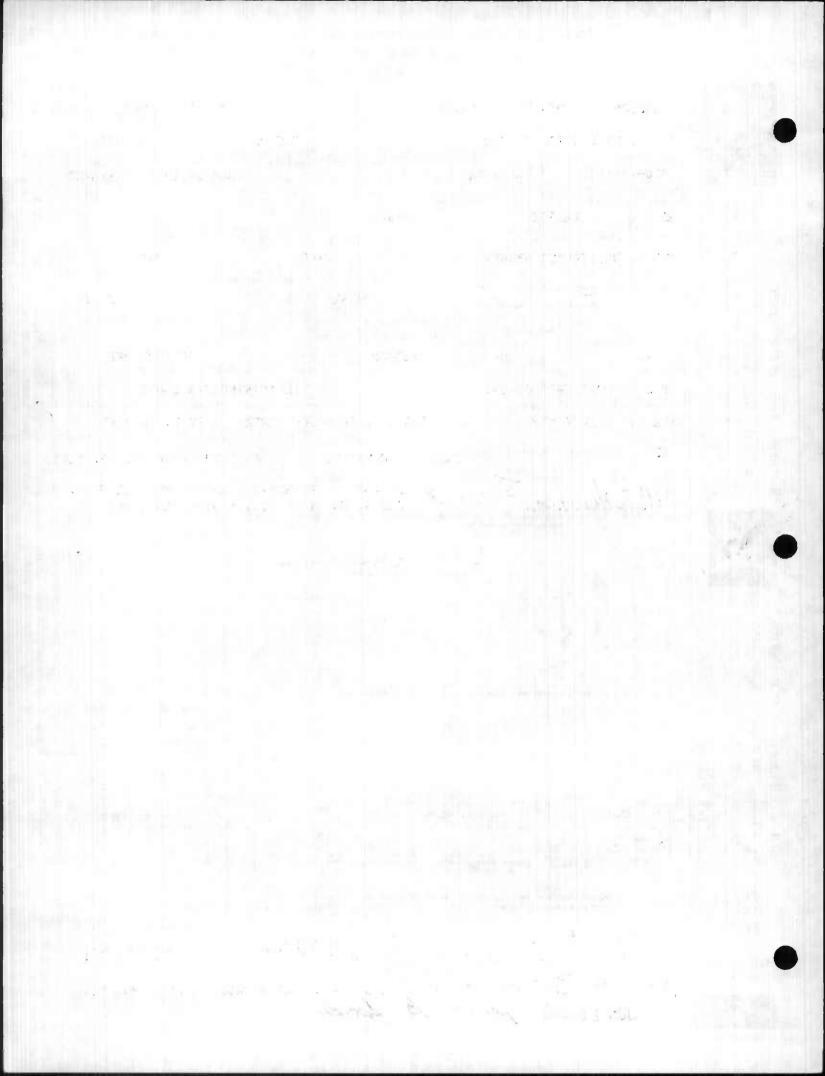
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician GEORGE** 1999 DUDLEY EBLING JUNE 17 7:20 AM · /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner 326 N. WASHINGTON STREET EASTON TALBOT If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 17 M 2□ F Yrs 220-12-1847 **Director** 74 JULY 18,1924 MARYLAND Usual Residence of Decedent the Maryland r 28a-f show 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD TALBOT 1 Yes 2 □ No EASTON Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pagas 1 and 2 should be filed within 72 hours aftar death with Department of Health and Mental Hygiene. Important: if item 27 is marked other than """ any injury or other traument. with 7 is marked other than "natural", or items 23s or traumatic awant, the Medical Examiner must be a 326 N. WASHINGTON STREET 21601 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14 Rece - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 ▼ No Specify: Specify: WHITE by 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementery/Secondary (0-12) College (1-4or 5+) -0-11 **FARMER** AGRICULTURE 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be PAUL STOUDT EBLING, SR. LILLIE VIRGINIA COHEE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) ANNA S. EBLING/ WIFE 326 N. WASHINGTON STREET, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date \*\*Burial 2 Cremation 3 Removal from State FAIRVIEW CEMETERY 6-21-99 CORDOVA, MD. 21625 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Neme and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 230 S. HARRISON ST., EASTON, MD 21601

23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. C.F.SP. Intervel Between Onset and Death Physician /Medical tmmediate Ceuse (Final disease or condition resulting in deeth) 10 mos avcinoma Examiner Due to (or as a consequence of): Examiner certificate be axecuted physician and the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events. Due to (or as a consequence of) Box 68760. Physician/Medical thet initiated events resulting in death) Last Due to (or as a consequence of) as USB 23b. Did tobacco use contribute to the cause of death? Part II. Other etanificant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö 1 Yee 2 No 3 Probably 4 Unknown ۵ Records. þ 8 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed page 2 cartificata has 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Wes cese referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 Residence 8 ☐ Other (Specify) 0 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28a. Dete of Injury (Month, Day Year) Natural 2 Accident 5 Pending 1 Yes 2 No daath. investigation after daati Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours Hospital 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the ceuse(s) and manner as stated. edicai complataly (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated. within 2 To the To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of deeth (Item 23a) (Type, Print) erson who con Ld S, M Mary 509 IDLEWILD AVENUE, EASTON, MD 21601

State Registrar 31. Dete filed (Month, Day, Year)

JUN 1 8 1999

32 Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ESKRIDGE DORRIS 25, 1999 4c. County of Death 12:30AM ATheliNe JUNE /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) Examiner mD CECIL NUISING CENTER ECKTON AUSELWOOD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** 10M 20F Days une 8, 1920 maryland 213-12-8465 Usual Residence of Decedent Yrs **Director** with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ttem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 Tes 2 No CECIL Director MD. ELKTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21921 4.5. A 205 LANDING LANC Funeral 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Merital Status permit. Pages 1 and 2 should be filed within 72 hours efter Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2 No Baltimore, Maryland 21215-0020 Specify Specify: WHITE by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) COUNTY Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dollis GREN ALFICO DOM15 To 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) ELKton MD. 21921 - HUSBAND 203 LANDING LANC ESKLIDGE 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ō June 25, 1499 West Chester PA. 5 ☐ Other (Specify) erris. Co any injury 4 Donation 21. Signature of Funeral Service Licenses 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) MININUTRITTOA Examiner Examiner ettending physician and for use es the burief-transit that the death certificate be executed Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown λq 24b. Were autopsy findings evaileble prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed certificate hes 2 2 No 1 Yes 1 Yes 2 No or Attending Physician: 25. Was cese referred to medicel examiner? Be 26. Piece of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Yes 2 No hours efter death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 24 hours 29a. Certifier Medicai 🔀 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. To the Vithin 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

3 Maudin 31. Dete filed (Month, Day, Year)

JUN 2 8 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Fast North MD 32. Registrar's Signature

901 Thomas E. Finucan MD

5

THE ROLL STREET JUNES 8 1833 / ---- / SEEL 8 18 MILL

	Flea	State of		d / Depa	artment of tificate o	Health a			-		21364		
Physician /Medical	Decedent's Nema (First, Midd		ar M.	Fishe	r			2. Date of D Month March	Day 1 29	Year L999	3. Tima of Death 7:45P		
Examiner	4a Facility Nama (If not Institution	The state of the s						ocation of Dea		y of Death			
Funeral Director	The Memori 5. Social Security Number 219-03-4701		7. Aga (In yrs.	last birthday) 8 Yrs.	If Undar 1 Ya Months Day			8. Date of B (Month, D	irth lay, Year)	_	plece (State or Foreign ntry)		
Meryland a-f show lind at	Usual Residence of Decedent 10a. Stata 10b. Count M D C a 1	roline	10c. Cit	y, Town or Lo	cation	F	ede	ralsb			10d. Inside City Limits 1 ☐ Yes 2 ☐ No		
ifier death with the Me r items 23s or 28s-1s ther must be notified Funeral Director	10e. Street and Number 611 Liberty	Road			10f. Zip Code	2163	2		10g. Citizen of United				
by	11. Marital Status  1 Never Married 2 Mai  3 Widowad 4 Divorce	Armed Fo 1 ✓ Yes If Yes Giv	2 🗆 No	1	Vas Decedent of Yes, specify C I□ Yes 2X□ N	ıban, Mexicar	gin? (Sp n, Puerto	ecity Yes or N Rican, etc.)		ck, White	can Indian, , etc. White		
ed within 72 ho ygiene. In the Medical I Completed	15. Decade (Spacify only highe Elementary/Secondary (0-12) 1 2	nt's Education est grade completed) College (1	-4or 5+)	16a. Deced (Give life. 1 Post	lent's Usuel Occ kind of work do DO NOT use ret al Cle	ne during mos ired)	t of work	ring	16b. Kind of E		tal Svc.		
Mentel Hyg orked other atic event, To Be C	17. Father's Name (First, Middle		is Fis	her		1211		a (First, Middle Benn	e, <i>Maid</i> en <i>Sum</i> a ett	me)			
end 2 sho eith and h 27 is me er traums	19a. Informant's Name/Relationship (Type, Print)  Cleda Gay Fisher/Spouse  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z 611 Liberty Rd., Federalsburg, MD												
Pages 1 nent of Hu int: If Itan iry or oth	20a. Method of Disposition  10 Purial 2 Cremation 4 Donation 5 Other (5		State	cemetery, cren	sition (Neme of natory or other) Shore		. 0	Date 4 / 0 2	Hurlo		own, State Maryland		
permit. Department imports any injures.	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Framptom - Hawkins - Eskow Funeral Hor Po. Box 43, Federal sburg, MD 21632												
Physician /Medicai Examiner	23a. Part1. Enter tha disease, o shook, or heart failure. Lis Immediate Cause (Final disease or condition	r complications that c	aused the deet ach line.	h. Do not ent	er the mode of o	lying, such es	cardiac	or respiratory	errest,	# 00 mm mm mm mm mm mm mm mm mm mm mm mm	Approximate Interval Between Onset and Daath		
<b>a</b>	resulting in death)	b. the	legs	ant	vence of	nou	1 1	hypit	way to	un			
o purio	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last	c	Due to (o	r as a conseq	uence of):	75-			H	1			
d by the letached	Pert II. Other algnificant conditi	one contributing to de	eath but not res	ulting In the u	nderlying cause	given in Part i	1.		tobacco usa c		to the cause of death?		
requires the peen signe should be differed by									es en autopsy formed?		Vere autopsy findings vallable prior to omplation of cause		

Edgar Fisher

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that tha deeth certificate be associted within 24 hours either death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit

Division of Vital Records, P.O. Box 68760,

Be Compl Medical Certification: To

of death?

1 Tes 212 No 26. Place of Deeth (Check only one)

28d. Describe how injury occurred

1 Yes 2 No

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 27. Menner of Deeth

5 Panding Investigation

6 Could not be determined

1 Minpatient 28a. Date of Injury (Month, Day Year)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work? Injury

28e. Placa of Injury - At home, farm, straat, factory, office building, atc. (Specify)

1 Yes 2 🗌 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)

2 Accident

3 Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and sittle of certifie

29c. License number D23066 29d. Data signed (Month, Day, Year)

30. Name and address or person who completed cause of death (Hem 23a) (Type, Print)
Stanley M. Bysshe, JR. M. D. 505 Dutchman's Lane, Easton, MD 21601

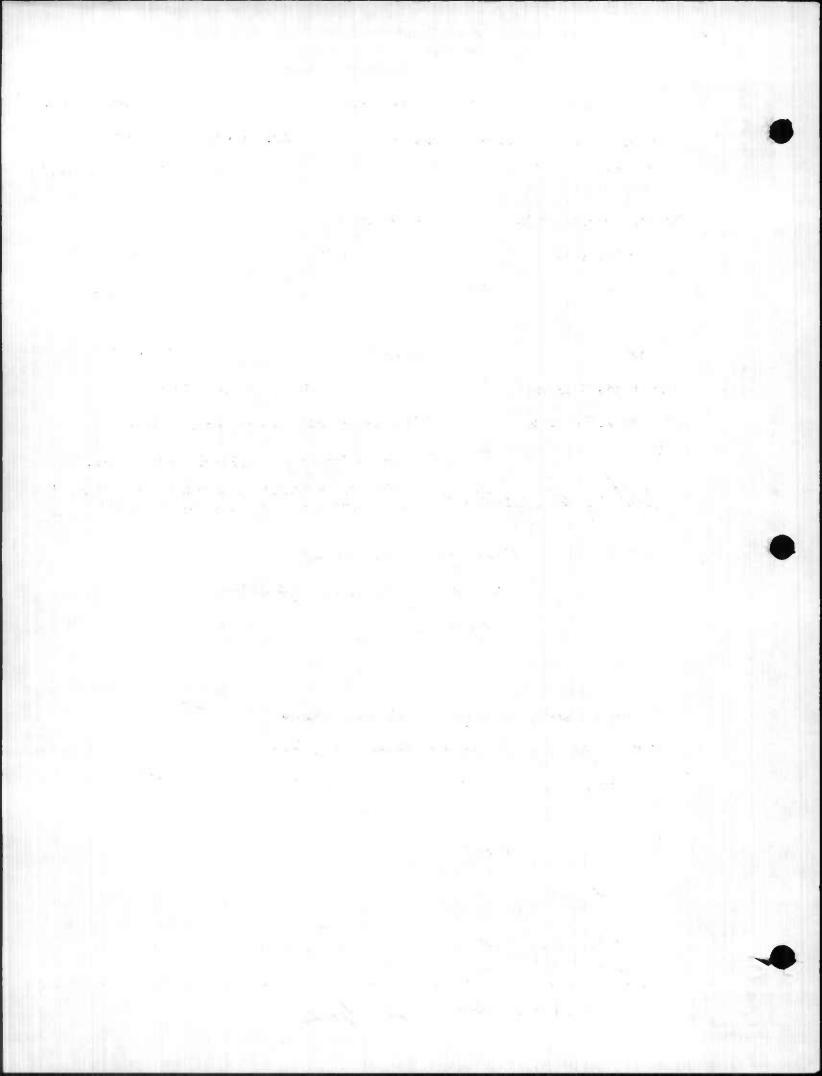
State Registrar 31. Data filed (Month, Day, Year) APR 0 2 32. Registrar's Signature 1999 ▶

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State of Maryland / Department of Health and Mental Hygiene

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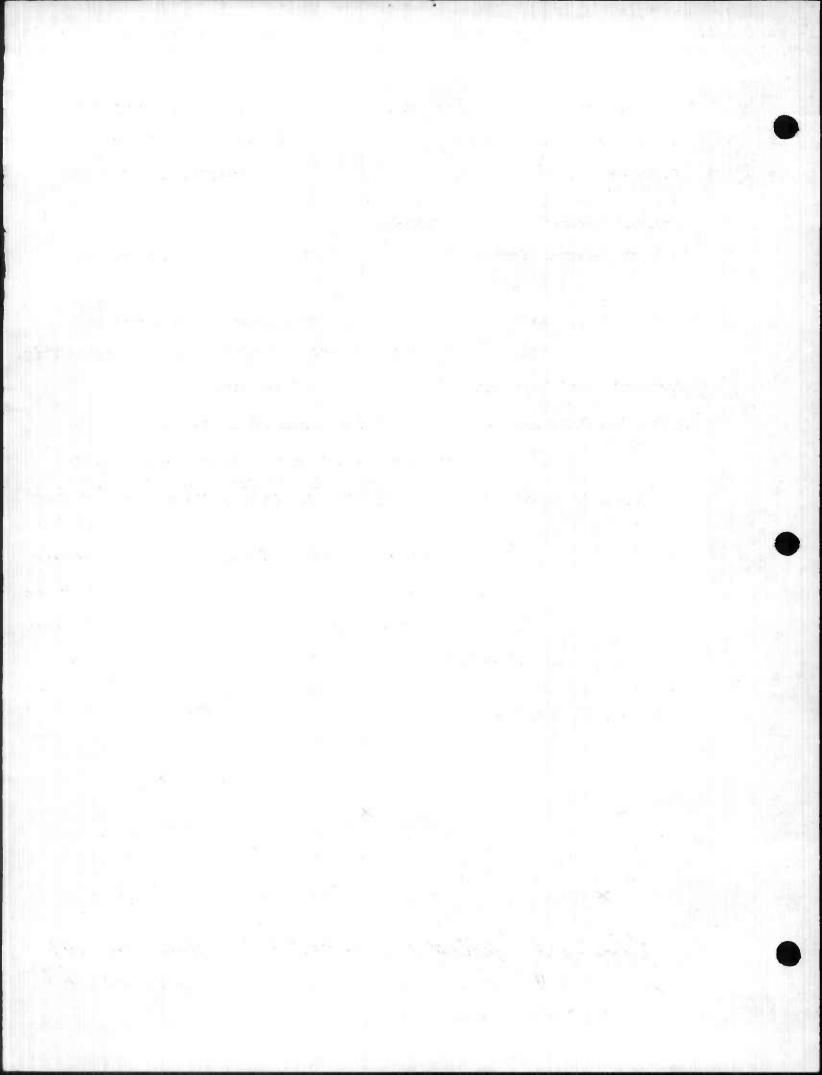
					Certificat	e of	Death			Reg. No.		
		1. Decedeni's Name (First, Midd	fle, Last)						2. Date of De		V	3. Time of Death
	Physician		.n J	(	reenwoo	d			June	$10^{ay}$ 1	ð <b>3</b> 9	0628
4	/Medical Examiner	An English Manna Hand Ingelievite	on, give street and number)				4b. City, To	wn, or L	ocation of Death	4c. County	of Death	
Ż.	LAdimine	The Kent and	Queen Anne's	Hospit		r 1 Year			rtown		ent	alana (Chata as Fassian
L	Funeral Director	219-62-9826 Usuel Residence of Decedent	6. Sex 1 XM 2 □ F	1.0	rs. Months	Days	Hours	Min.	Sept.	11, 1955	Chest	place (State or Foreign ntry) tertown, MD
	yland	10a. State 10b. Count	у	10c. City, Town	or Location						1	Od. Inside City Limits
	Mar	Maryland Queen	Anne's	Che	stertow	m						1 ☐ Yes 2 No
	or 28a-f s	10e. Street and Number			10f. Zip	Code				10g. Citizen of V	Vhat Cour	ntry?
	ifh with wind with wind with wind with wind with wind wind wind wind wind wind wind wind		ad		2	1620	)			USA		
20	n 72 hours after death with the Maryland "naturel", or items 23a or 28a-f show solical Examiner must be notified at		If Yes, Give		13. Was Dece If Yes, spe 1 Yes				ecify Yas or No Rican, etc.)	Haci Blac Specify	k, White,	can Indian, etc. ite
8	hour turaf	3 Widowed 4 Zabivorce	d Year or Dates:	160	Decedent's Usu	al Occur	nation			16b. Kind of Bu	siness/in	dustry
21215-0020	S 1 # 7	(Specify only high	est grade completed)		(Give kind of wo life. DO NOT u	rk done	during mos	t of work	ing	TOD. KING OF DO	10111000111	oddify
212	should be filled within and Mentel Hygiane. I marked other than "I umatic event, the Mac	Elementary/Secondary (0-12)	College (1-4or 5	+) Mar	ager					Pest Co	ntro	1
	should be filed at Mentel Hygid marked other imatic event, To Re Co		, Last)				18. Moths	ar's Nam	e (First, Middle	, Maiden Surnem	Θ)	
Maryland	Mente de la la la la la la la la la la la la la		enwood				Bett	v L	ouise We	eller		
ary	d 2 should the and Men 7 is marke traumatic	19a. Informent's Neme/Reletion	ship (Type, Print)	19b.	Malling Address	s (Street				er, City or Town,	State, Zip	Code)
	こうれて	Kelly Foxwell/F	iance	233	Warwic	k Ro	oad, C	Chest	tertown	, MD 216	20	
altimore,	Pagas 1 ent ent of Haalt nt: If Item 2: ry or other	20a. Method of Disposition  1   ↑ Burial 2   ☐ Cremation  4  ☐ Donation 5  ☐ Other (3)		cemeter	Disposition (Nat y, crematory or o SVIIIe	other pla			Date 5/13/99	20c. Location - Sudlers		
Balti	permit. Pagas 'Department of F Important: If ite any injury or of once.	21. Signature of Funeral Service	1 111		22. Name at	nd Addre	ess of Facili	ly nein	& Nown:	am Funor		ome, P.A.
		23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that caused	the death. Do n	130 Spe	er I	Road,	Ches	stertown or respiratory a	n, MD 2	1620	Approximate
	Physician /Medical Examiner	shock, or heart tawore. List Immediate Cause (Final disease or condition resulting in death)	a. Cano:									Intarval Between Onset and Death
	. 111			Due to (or es e	onsequence of)		· T	,				
	to be assecuted sician end burial-transit		b. Acu	ce nu	pocend	eal	ny	inc	fran		1	
•	axecu n end ial-tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1/	Due to (or es eu	onsequence of):						1	
68760,	icata be physicials the burns of ical		c	perfect Due to (or as a c	onsequence of):							
Box 68	F 5 8 2		d	500 10 (01 03 0 0	orisoquorioo ory.						1	
8	daath sa atter se affor u	Part II. Other significant conditi	ione contributing to death bu	it not resulting in	the underlying	cause gi	ven in Part	l.	23b. Did	tobacco use cor	ntribute t	o the cause of death?
, P.O	es that the death ce igned by the attend be deteched for us.		quel, Histon						12	Vee 2□No	3 ☐ Pro	bably 4 Unknow
Records,	aw requir	Non comple	ame to m	ledicas	Lines ,	41	ston	1_	24a. Was	an autopsy ormed?	av	fere autopsy findings vallable prior to empletion of cause death?
Ä	00 10 10	Iv some	uce greate	1 Than	100	ean	1220		10	Yes 2110	11	☐Yes 2☐ No
Vital	s certificata director, pag	25 Was case referred to medic	al	7,000	- 100		28. Place	e of Dea	th (Check only	one)		
of V	S 50 5	1 Yas 2 No	Hospital: 1 ☐ Inpatie	nt 2 ER/Ou	patient 3 19 0	OA O	her: 4 🗆 Nı	ursing H	ome 5 Resi	idence 6 DOth	ar (Speci	(ty)
	After th funeral		28a. Date of Injur (Month, Day	y Year) 28b. T	ime of	28c. Inju Wo	ry at		28d. Describe	how injury occur	red	
Division	tal or Attending P is aftar daath.  Is Director: Aftar t ed in by the funers Certification:	2 Accident invest	tigation None		М		Yes 2	No				
Š	or Attendi after death. Director: A 3 in by the fi	3 Suicide 6 Could 4 Homicide deter	mined 28e. Place of Inju-	iry - At home, fai (Specify)	m, street, factor	y, office			28f. Location ( City or To	Street and Numb wn, State)	er or Run	al Route Number,
	ital o											
	To the Hospital of within 24 hours at To the Funeral D complately filled in Medical Ce.		ing Physician: To the best of I Examiner: On the basis of and manner sta	examination and								
	To the common	29b. Signature and title of certifi	er O		29		se number			29d. Date signe		
	1	0 Cled	was Mil			95	388	9		6/10	19	9
V		30. Name and address of person To line ( . Arek	who completed cause of di	eeth (Item 23e) (	Type, Print)	chen	ife	Ave	Ph10-4			
	State	31. Date filed (Month, Day, Year	r) 32. Registre	ar's Signature			Ks	,,,,,	- CARROL	-111-0-00	, 10	2 01420
	Registrar				1- 19	pou	KS					



State of Maryland / Department of Health and Mental Hygiene

			State of Wallylan		tificate of			ig. No.	21000
	Dharaist		Decedent's Name (First, Middle, Last)				2. Dete of Deeth Month	1	3. Time of Careth
	PhysicI /Medic			raves			Tune,	13, 199	9 17:25
	Examir		4a. Facility Name (If not institution, give street and number)	,		4b. City, Town, or Lo	cation of Death	4c. County of [	Death
			Howard County Gener	8/		Columbi	.a	Howa	rd
	Funeral Director		5. Social Security Number  360-24-5096  Usual Residence of Decedent  6. Sex  1 □ X M 2 □ F  68	last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Jan. 28	Year) 9. 1931	Birthpiace (Stata or Foraign Country) Illinois
	show dat		The state of the s	ty, Town or Loca	ation				10d. Inside City Limits
	8a-f	Director		Columbi					1 ☐ Yes 2 🕅 No
	vith th	급	10e. Street and Number		10f. Zip Code		10	g. Citizen of Wha	
	s 234	eral	5693 Unit D Harpers Farm Road	6 40.14	210		-14. VN-	United S	States American Indian.
21215-0020	within 72 hours after deeth with the Maryland ene. than "natural", or items 23s or 28s-f show the Madical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U. Armed Forces?  1 XYes 2 No It Yes, Give Year or Dates: UNKNo	1[	Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto Spacify:	Rican, etc.)		White, etc.  Black
5-0	ithin 72 hours: 6. an "natural", an "natural", d	ted	15. Decedent's Education (Specify only highast grada complated)	16a. Decede	ent's Usual Occup	pation during most of worki	na 1	16b. Kind of Busin	ess/Industry
2	within one.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. Do	O NOT usa ratire	d)			
	TO TO be and	Con	5+	Execu	tive Dep	outy Direc			ecurity Admin.
and	o d a b	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		fa <i>id</i> an <i>Sum</i> ama)	
N N	should be and Mental marked o	To	Clarence Richard Graves Sr.	1		Lillian K			
Maryland	2 s s s s s		19a. Informant's Name/Relationship (Type, Print)			and Number or Rura			
	of Heelth Item 27 i		Sandra Blank/Daughter 20a. Method of Disposition 20b. P			Avenue Bal	-	Mary Land Oc. Location - City	
non	o to		Tabular 2 Cremation 3 Phenoval non State		ition (Name of atory or other pla				
Baltimore,			4 □ Donation 5 □ Other (Specify) CO  21. Signature of Funeral Service Licensee		Memoria] Name and Addre			Clarksvil	
Ba	permit. Depertr Imports any Injt		Den a Colling- Wity	41	12 01d C		ike Ell:	loott Cit	y, MD 21043
			23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.	h. Do not enter	r the mode of dyir	ng, such as cerdiac c	or respiretory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Finel disease or condition resulting In death)	rdiai	In	farcti	on		Thoun 15 years
		er	Due to (o	or as a consequ	ence of):				15
	uted d ansit	Examiner		tens or as a conseque	MA				1) 4000
Ć.	ificete be executed g physicien end es the buriel-transit	Еха	if any, leading to immediate		enca or):				50
68760,	ysicie	edicai	Cause (Disease or injury that initiated events	or as a conseque	naccof):				years
	5 00		resulting in death) Last  d. Obe S17						20 years
Вох	atten for u	Physician/N	,	<i>'</i>					
P.O.	that the de led by the a detached f	hysi	Pert II. Other algnificant conditions contributing to death but not rest	ulting in the und	derlying cause giv	ven in Part I.	23b. Did to		bute to the cause of death?  Probably 4 Unknown
	es that igned to be det	by P	High Cholesteral					ns ZIINO S	
Records,	been s	Completed b					24e. Wes ar perform		4b. Were autopsy findings available prior to completion of cause of death?
	The lew ete has page 2	E O					1□ Ye	s 20 No	1 ☐ Yes 2 ☐ No
ta		Be C	25. Was case referred to medical			26. Place of Death		-	
of Vital	ysician: is certific director,	ToE	examiner? 1 ☐ Yes 2 ☐ No Hospitai: 1 ☐ Inpatient 2 ☐	ER/Outpatient	300A Oth	ner·		nce 6 Other (	Specify)
	Attending Physician: or deeth. actor: After this certific by the funeral director,		27. Manner of Death  1 2 Natural 5 Pending (Month, Dey Year) 2 Accident investigation	28b. Time of Injury	28c. Injui Wo M 1	ryat rk?  Yes 2 □ No	28d. Describe ho	w Injury occurred	
Division	at or Attending Plant of the setter deeth. I Director: After till of in by the funera	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Placa of Injury - At ht building, etc. (Spacify	ome, farm, stree y)	et, factory, office		28f. Location (Sti City or Town		or Rural Route Number,
	To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by th	edical (	29a. Certifier (Check only one)  Certifying Physicien: To the best of my kno and manner stated.	wledge, deeth o tion end/or Inve	occurred et the tir estigation, in my o	me, date end placa, a opinion, death occurr	and due to the ce ed et the time, de	ouse(s) and manne ete end piece, and	er as stated. I due to the cause(s)
	To the To the Comp	M	29b. Signature end title of cartifier		29c. Licens		25	d. Date signed (A	Aonth, Day, Year)
	,		Chaley V. hellots	7 MD	D 3	4195	$\mathcal{J}$	une. 12	+ 1999
	15		30. Name and eddress of person who completed cause of death (Item	n 23a) (Type, P	rint)	A .		).	+, 1999 HCity hD
			Chesley W Tettott MD,	84921	Bultimor	ne Patjo	nal Pik	e Ellico	HCITYND
	Sta Registr		31. Date filed (Month, Dey, Yeer)  32. Registrar's Signa  JUN 1 6 1999	iture 4	1.				

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

					arylalia / E		ficate of			Reg. No.	2 4	1.0-7
	Physici	ian	Decedent's Nema (First, Middla,	Last)					2. Data of Dei Month	Dey	Year	3. Time of Death
	/Medi		Anna Elizabeth							20 199		10:29pm
7	Examir	ner	4a. Facility Nama (If not Institution,	- Hillings Hills House Co.					r Location of Death			
_			123 Wilson Stree  5. Social Sacurity Number		a the sum in at his	dh da cal	f If Undar 1 Year	Havre de		Harfo		400
	Funeral Director		214-26-3307 Usual Residence of Dacedant	1 M 2 K	e (In yrs. iast bir 93		Months Deys			y, Year) 1905	9. Birthplace Country MD	e (State or Foreign
	land		10a. Stata 10b. County		10c. City, Tow	n or Local	tion				10d.	Inside City Limits
	Mary Hah	to	MD Harfo	rd	Havre	de de	Grace					1 X Yes 2 □ No
	r 28s	Director	10e. Street end Number		11411		10f. Zlp Code			10g. Citizan of N	What Country	7
	h wit		123 Wilson Stre	e†			21078	3		USA		
	dea	Funeral	11. Maritel Stetus	12. Was Decedent I	Ever In U,S.	13. Wa	s Decedent of I		Specify Yes or No	- 14. Red	e - American ck, Whita, etc.	
Maryland 21215-0020	filed within 72 hours after death with the Maryland thygiene. ther than "natural", or Reme 23a or 28a-f show ther than Redical Examiner must be notified at	by	1 ☐ Nevar Marriad 2 ☐ Marrie 3 🂢 Widowed 4 ☐ Divorced	Armed Forces? d 1 ☐ Yas 2 ☑ Armed Forces? f Yas, Giva Yaar or Datas:	No		Yes 20XNo		110 1110 111, 010.)	Specify		
5-0	72 hc	Completed	15. Decedent's (Specify only highest	Education grada completed)	16a.	Deceder (Giva kir.	nt's Usual Occup and of work dona	pation during most of w	orkina	16b. Kind of B	usiness/indus	try
121	I within 72 ho iene. 'than "natur the Medical	щ	Elamantary/Secondary (0-12)	Cotlega (1-4or 5	i+)	lifa. DO	NOT usa retire	(d)				
7	e filed withing the file of th		4th 17. Fathar's Nama (First, Middia, L.	net)		Hom	emaker	T	ama (First, Middla,	Home	a l	
an	8 4 5 9	Be C		131/				1000			181)	
2	d 2 should be th and Mental 7 Is marked or traumatic eve	2	Lewis G. Miller  19a. Informant's Name/Ralationshi	n (Type Print)	19h	Mailing	Arldrass /Strae		W. Walke		State 7in Co	rde)
Z	d 2		Marlene Dennis						lavre de			
re,	- 9 5 5		20a. Mathod of Disposition	Duagntei	20b. Place of	Dispositi			Data	20c. Location -		
E			1 X Burial 2 ☐ Crametion 3 4 ☐ Donation 5 ☐ Other (Spe					Grdns.	6/25/99	Aberd	oon M	AD.
Baltimore,	4464		21. Signeture of Funeral Service Li		Tial Tol	22. N	lama and Addra	ass of Facility				10
m	Page 1		Mu King	m. Sn	nite				neral Hon			21070
			23a Parti Enter tha disaasa, or c	omplications that caused	tha daath. Do				Havre of ac or respiratory as		Ac	proximata
	Physician		and, or neer lands. List of	ny ona cause on aaon iii	161.							tarvat Between nset and Death
	/Medical	K.	Immediata Cause (Finel diseese or condition	L	-unq	2	Canci	1			8	Monitis
	Examiner		rasulting In daath)	a	Due to (or as a							
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	ificate be executed g physician and as the burial-transit	xar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury		Dua to (or as e	consequa	nce of):					
68760,	siciar b buri	edical	Cause (Disaase or Injury that initiated evants	c	Dua 40 /00 00 0							
	E 0 6		rasulting in death) Last		Dua to (or as a c	conseque	nce or):					
ROX	attending for use	1		d								
	hat the death cert ed by the attendin detached for use	Physician/M	Part It. Other significant condition	a contributing to death be	ut not resulting in	tha unda	artying causa gi	van in Part t.	23b. Did	lobacco use co	ntribute to th	e cause of death?
л. О.	- 02	Phy	Campada	artiru de	de as				10	Yes 20 No	3 Probab	ly 4 ☐ Unknow
	Se G	þ	Coronary	1					-			
Division of Vital Records,	pear / requ	Completed							24e. Was perfo	an eutopsy med?	avalla	autopsy findings bla prior to lation of cause
ě Y	has ye 2	dmo									of dea	
ā	delan: The certificate rector, pag		25. Was case referred to medicat					OC Plans of D	10		1 LI Y	as 2 No
>		To Be	axaminar?	Hospital: 1 ☐ Inpatia	nt 2□ ER/Ou	tnatient	3□ DOA Ot	han	Homa 5 Rasto		er (Specify)	
0	Physical dispersion		27. Manner of Death	28a. Date of injur	ry 28b. 1	Tima of	28c. Inju			now Injury occur		
Ö	Attending in death. Sector: After by the fune	atio	1 ☐ Maturat 5 ☐ Panding 2 ☐ Accidant invastiga	(Month, Day	rear) I	njury		Yaa 2 No				
<u> </u>	al or Attending Physis after death. Il Director: After this ed in by the funeral di	Certification:	3 ☐ Sulcide 6 ☐ Could no 4 ☐ Homicida detarmin		ury - At home, fe	rm, atraat	, factory, offica		28f. Location (S City or Tox	Street and Numb	er or Rural R	outa Number,
2	tral o											
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifiar  (Check only one)  1 ☐ Certifying  2 ☐ Medical Ex	Physician: To the best of caminer: On the basis of end manner ata	axamination and	, daath oo d/or Invas	courred at tha ti tigation, in my	ma, date end pled opinion, daath occ	ce, and due to tha curred et tha time,	causa(s) and mo dete and placa,	anner as state and dua to the	od. a causa(s)
	To the within 2 To the Complet	Me	29b. Signature end title of certifier				29c. Licens	se number		29d. Data signe	d (Month, Day	y, Year)
			▶ Wh	iran 1	M		D 3	32609		6/22	99	
7	9		30. Nama and addrass of person w	no completed cause of di	aath (Item 23e) (	(Type, Pri	nt)					
	,		Kammeler	Muhan	10 41	3 R	evoluit	Tonst.	HUNTE L	) E Gom	1100	2/078
	Sta Registr	_	29b. Signature end title of certifier  30. Nama and addrass of person w  Commellum  31. Data filled (Month, Day, Year)  JUN 2.3	199 Jeps	or s Signatura	9.	Sport	V	1			

DHMH 16 Ray 6/95

288 ( 1 NO.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** RENSSELAER Leslie 19 Holdridge June 1999 2:35 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis ElderCare -The Pines Easton Talbot If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Yeer) Birthpleca (Stete or Foreign Country) **Funeral** 1 M 2□ F Months Days Hours Min 91 Yrs. Director SEPT. 29,1907 CONN. 215-44-7199 Usual Residence of Deceden the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23s or 28s-f ahow the Medical Examiner must be notified at MARYLAND

10e. Street and Yes 2 No TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 205 SPRING DRIVE 21601 U.S. Funeral death permit. Peges 1 and 2 should be filed within 72 hours after deal Depertment of Heelth and Mentel Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumetic even. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian Was Decadant Evar In U,S. Armed Forcas? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yas 2 No 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) DEMDROLOGIST U.S. FOREST SERVICE 18 Mother's Name (First, Middle, Meiden Sumema) 17. Father's Name (First, Middle, Last) SAMUEL L. HOLDRIDGE PHOEBE J. HOLMES 19a. Informent's Name/Retationship (Type, Print) 19b. Mailing Address (Straet end Number or Rurel Route Number, City or Town, Stete, Zip Code) LYDIA R. HOLDRIDGE/WIFE 205 SPRING DRIVE, EASTON, MD. 21601 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) CHES. CREMATION CTR. 6-21-99 CHESTER, MD. 21. Signature of Funeral Service Licenses 22. Name end Address of Facility
FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME Ostrowsk Joseph 200 S. HARRISON ST. EASTON, MD. 21601 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter tha mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate tntarval Batween Onset and Death **Physician** Immediate Cause (Final disease or condition rasulting in death) /Medical PNEUMONIA **Examiner** Due to (or es a consequence of) Examiner ician and burial-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Undarlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or as e consequence of): certificete be exec Box 68760 physician Physician/Medical the Due to (or es e consequence of) 88 use Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown á bengis à Division of Vital Records. 24b. Wera eutopsy findings available prior to completion of cause of death? 24e. Was en autopsy performed? Completed peed hes 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 9 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. tnjury at Work? Certification: After Attending 5 Pending Investigation after death. 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 - Homicide ò 24 hours a Hospital 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end pleca, and due to the ceuse(s) end manner as steted. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end placa, and due to the ceuse(s) end manner stated. To the Within 2 29b. Signeture and title of certifier 29c. Licansa numbar 29d. Data signed (Month, Dey, Year) es 30. Name and address of person who comple ed cause of death (item 23a) (Type, Print) 9 James 31. Date filed (Month, Dey, Year) 32. Régistrar's Signature

State Registrar

1999

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State of Maryland / Department of Health and Mental Hygiene

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			Certificate of	Death	Re	eg. No.	4 1 6	
Discontation	1. Decedent's Name (First, Middle, Li	ist)			2. Dete of Deat Month	h Dey	3. Time	of Death
Physician /Medical	Harvey R. Harten	stine			June 0			)_A.M.
Examiner	4a Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or L		4c. County		)
	1614 Busic Churc	h Poad		Sudlersv	1110	Orioor	Annote	
Funeral		Sex 7. Age (In yrs.	last birthday) If Under 1 Yea	if Under 24 Hrs.	8 Date of Birth		9. Birthplece (Stell Country)	e or Foreign
Director	204-14-2803	1⊠M 2□F 75	Yrs. Months Days	Hours Min.	(Month, Day, Feb. 23,		Pennsylv	onio
JII ECTOI	Usual Residence of Decedent	/3			reb. 23,	1924	rennsylv	ania
B 10	10a. State 10b. County	10c. Ci	ty, Town or Location				10d. inside	City Limits
and at Or	NG 0	Mc Mc	rudo1				1 DY	es 2 No
r matte notified at	MD Queen A	nne's Pla	rydel			On Citines of 1	After Courses	
급	TOB. SUBSE and Number		10f, Zip Code			og. Citizen of t	What Country?	
Ta I	1614 Busic Churc		2164			U.S.A		
Funeral Director	11. Meritat Status	12. Was Decedent Ever in L Armed Forces?	,S. 13. Was Decedent of It Yes, specify Cu	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ce - American Indian ck, White, etc.	
	1 Never Married 2 Married	1 ☑ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 🖾 No			Specify		
1 by	3 Widowed 4 Divorced	Year or Dates: WWI				Specin	White	
ě	15. Decedent's E (Specify only highest gr		16a. Decedent's Usual Occu	upation	ina	16b. Kind of B	usiness/Industry	
de	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work don life. DO NOT use retir	ed)				
Be Completed	12		Gauge Maker			Gauge M	Manufactui	rer
Be C	17. Father's Name (First, Middle, Last	)		18. Mother's Nem	e (First, Middle, M	Maiden Suman	ne)	
.0	Harvey Hartenst:	ine		Beaulah	Barto			
-	19a. Informant's Name/Relationship		19b. Meiling Address (Street			City or Town.	State, Zip Code)	
	Janet Hartenstin		1614 Busic O				21649	
	20a. Method of Disposition		Place of Disposition (Name of	muren Roa			City or Town, State	
	1 ☐ Burial 2 ☐ Cremetion 3 ☐		cemetery, crematory or other pl	lece) Ju	ne 9, 19	99	City of Town, State	
	4 ☐ Donation 5 ☐ Other (Speci	(h) Ch	esapeake Crema	tion Cente	er S	stevens	ville, MD	
any injury o	21. Signature of Funeral Service Lice	nysee	22. Neme end Add					
28	1/1.		Fellows, F	Helfenbein	& Newna	m Funer	ral Home,	P.A.
	23a. Part1. Enter the disease, or con	unlinations that caused the dea	PO Box 270				-02/0 Approxir	nete
	shock, or heart failure. List only	one cause on each line.	in. Do not enter the mode of dy	yang, door os carolec	or respiretory ent	551,	tnterval I	Between
ian ical	Immediate Cause (Finel	0		. 0				
er ,	disease or condition resulting in death)	. Cutting (	Journal of	Nech				
	,	De to (	or as a consequence of):					
ine		1						
Examiner	Sequentially tist conditions,	Due to (	or es e consequence of):					
	Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
edical Examin	that initiated events	C. Due to fo	or es a consequence of):					
	resulting in death) Last	223 10 (1						
3		d						
y Physician/Med					1			
yst	Part It. Other significant conditions of	contributing to death but not res	ulting in the underlying cause of	given in Pert I.	23b. Did to	bacco usa co	ntributa to the cau	as of death?
4					1 🗆 Y	es 2 No	3 Probably 4	Unknown
þ								
8					24a. Was a perform		24b. Were autop available pri	or to
Completed							completion of death?	
Comp					1Kv	s 2 No	1 Yes	2□ No
ŏ	25 Was rare mlared to mades!			00.51	100		A res	
B	25. Was case referred to medical examiner?	Hospital:		ther:	th (Check only on			
To Be	Yes 2 No	1 LI Inpatient 2 L	ENOutpatient 3LJ DOA	4 LI Nursing P	ome 5 X Reside			
ed in by the funeral Certification:	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. tnj tnjury W		28d. Describe bo	M injury occur	Ted O	
cati	2 Accident investigation	10000001	6 KJ AM 11	☐ Yes 2 No	rojec	(sel 8	ey	
t de	31 Suicide 6 Could not be determined	28e. Place of tnjury - At h building, etc. (Speci	ome, farm, street, factory, offici	9	28f. Location (St. City or Town	reet end Numb	ber of Rural Route N	lumber,
		Yes			Road Ju	decisi		
	29a. Certifier 1☐ Certifying Pf	ysician: To the best of my kno	wledge, deeth occurred et the	time, date and place.	-	ause(s) and ma	anner as stated.	
lately filled			ition and/or investigation, in my					e(s)
7 5 6								

30. Name and address of person who completed cause of beath (Item 23a) (Type, Print) State

THESPILE MILLIN 31. Date filed (Month, Day, Year)

JUN 1 0 1999

29b. Signature and title of certified

32. Registrar's Signeture

111 Penn Street, Baltimore, Maryland 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

June 08, 1999

Registrar

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se	Type or Print in Black Indelible ink. Assure All Copies Are Legible.			
	State of Maryland / Department of Health and Mental Hygiene		70	
	Certificate of Death			

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	Physicia		1. Decedent's Name (First, Middle,		YY WK.					2.	Date of Death Month		Year	3. Time of Death
E.	/Medica		ELSIE	MARIE		HALL		_			June 1	4, 199	9	7:56 A.M
	Examine Funeral Director		219-60-0284			rs. last birthday, Yrs.	If Under 1 \ Months D		If Under 24	Cess Hrs. 8.	Anne Date of Birth (Month, Day,	Year)	merse	et lace (State or Foreign try) YLAND
	the Maryland 28a-f show notfiled.at	Director	Usual Residence of Decedent  10a. State 10b. County  MARYLAND SOMERSI  10e. Street and Number	ĒT		City, Town or L		ode			10	Og. Citizen of		0d. Inside City Limits 1 ☐ Yes 2 1 No
			28942 MT. VERNOI	N ROAD			2185	53					USA	
020	e sun	by Funeral	11. Marital Status  1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed F	2 No	U,S. 13.	Was Decedent If Yes, specify	Cube	ispanic Origin an, Mexican, F Specify:	? (Specify Puerto Ric	y Yes or No- an, etc.)		ce - Americ ck, White, by:	
21215-0020	72 ho 'natur dical	Completed	15. Decedent's (Specify only highest)		0	16a. Dece	dent's Usual O kind of work of DO NOT use r	occup	ation during most of	f working	1	16b. Kind of B	usinass/Inc	Justry
212	within then the Me	dwo	Elementary/Secondary (0-12)	College	(1-4or 5+)		EWIFE	retired	1)		30	OWN HO	ME	
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yla	Ment Ment mrkad wite e	10	LOUIS ALLAN HICH								ZABETH			
, Maryland	and 2 sh arth and 27 is m or treum		19a. Informant's Neme/Relationship STACEY BLAKE/DAI				ng Address (S 1 MT. \							
Baltimore,	Pages 1.		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spe		n Stete	Place of Disp cemetery, cre	matory or othe	r plac	•			CRISFI		
	Physician /Medical Examiner		21 Shipature of Funeral Service Like 21 Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in deeth)	lenn	10515	H:	ter the mode o	un	eral Ho rset A	ve.	Prince	ess Ann	e. Md	21853 Approximate Interval Batween Onset and Death
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,092		cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	6. CTROI		o (or es e conse	quence of):				>= E			
ox 687	2 82 .	Physician/Medic	that initiated events resulting in death) Last	d	Due to	(or as a conse	quence of):					1		
00	the atter	SICIB	Part It. Other eignificant conditions	contributing to	death but not r	resulting in the o	inderlying caus	sa giv	en in Pert f.		23b. Dfd to	bacco uee co	ontribute to	the cause of death?
s, P.O	es that the de igned by the be detached	by Phy	SEIZURE DISORDER							_	1 🗆 Ye	2□ No	3 to Prol	bebly 4 Unknow
Record	v requir been s should	Completed								_	24a. Was ar perform	ned?	co of	ara autopsy findings allable prior to mpletion of cause death?
	lclan: The lav certificate hes rector, page 2	S •	Of 18tes and actioned to medical								1 X Ya		1,5	Yas 2□ No
Vital	s certific director,	0	25. Was case referred to medical examiner?  1 ☑ Yes 2 ☐ No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Oth	or		50 Reside		her (Snecif	w)
n of	2 2 2	-	27. Manner of Death	28a. Date (Mo	e of Injury onth, Day Year)	28b. Tima d	of 28c.	. Injur Wor	y at k?	280	Describe ho			
Division	t hours after death.  uneral Director: After	Certification:	2 Accident investigal 3 Suicide 6 Could not determine	be 28e. Plac	ce of Injury - Al ding, etc. (Spe	t home, farm, si	m reet, factory, o		Yes 2 □ No		Location (St. City or Town	reet and Num , State)	ber or Rura	al Route Number,
	t hours a uneral lely filled	Cal	29a, Cartifier (Check only 2K) Medical Ex	Phyefcian: To the										

State

Registrar

DHMH 16 Rev 6/95

Stephen S, Radentz,

31. Date filled (Month, Day, Year)
Ammended by Somerset County, Health Dept.

HIN-1-2-1999

30. Name and address of person who complated cause of death (flem &3a) (Type, Print)

29c. License number

O.C.M.E.

JUN 2 1 1999

**ORIGINAL** 

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

June 15, 1999

mention of warring

184 5 3 1899 JULE 1 1893

### Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Month 1999 Frances Cecilia Ann Holland 438 une 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Fallston General Hospital Fallston Harford If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Yaar 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) 1□ M 2☑ F Months Days Yrs Maryland July 25, 1938 213-36-8501 60 Usual Residenca of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. inside City Limits Harford Abingdon Maryland 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21009 USA 123 Waldon Road, Apt. H Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian Biack, White, etc. 1 Never Marriad 2 Married Specify: Black 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elamentary/Secondary (0-12) Board of Education Custodian 12 18. Mother's Name (First, Middla, Maldan Sumama) 17. Father's Name (First, Middla, Last) Margaret Frances Frisby Charles Edward Washington 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 25 Patrick Court, Abingdon, MD 21009 Doreen Washington/Daughter 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) Highview Memorial Grdns. 6-25-99 Fallston, Maryland of Funeral Service Licanser 22. Name and Addrass of Facility McComas Funeral Home, P.A. Comas 21009 1317 Cokesbury Road, Abingdon, MD 23a. Part1. Enter the classes, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haar is ura. List only one cause on each line. Approximata Interval Between Onsat and Death Immediate Causa (Final CIRRHOSIS disaasa or condition resulting in daath) Dua to (or as a consaquanca of): SEPSIS Due to (or as a consequence of): HROMBOCYTOPENIA Due to (or as a consequenca of) TYPOTENSION 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy

**Physician** /Medical Examiner

physician end s the burial-transit

ettending pl

been signed by the should be detached

certificate has t lirector, page 2 s

Hospital or Attending Physician: 24 hours effer death. Funeral Director: After this certifics stely filled in by the funeral director, i

To the Hospital or within 24 hours eff To the Funeral Di completely filled in

by

Completed

Be

Certification: To

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Division of Vital Records.

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Department of Important: If any Injury or pace.

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**Physician** 

/Medical

Examiner

Directo

Funeral

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Completed

**Funeral** 

**Director** 

Peges 1 end 2 should be filled within 72 hours efter death with the Maryland nent of Heelth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or item 23s or 28s-f show any or other traumetic event, or Neddell Examinet must be notified.

Examiner Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Were autopsy findings available prior to completion of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Chack only one) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yas 2 No 2 Accidant 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Cartifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the causa(s) and mannar steted.

29b. Signature and title of cartifier

31. Date filed (Month, Day, Year)

29c. Licensa number

D45921

29d. Date signed (Month, Day, Year)

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

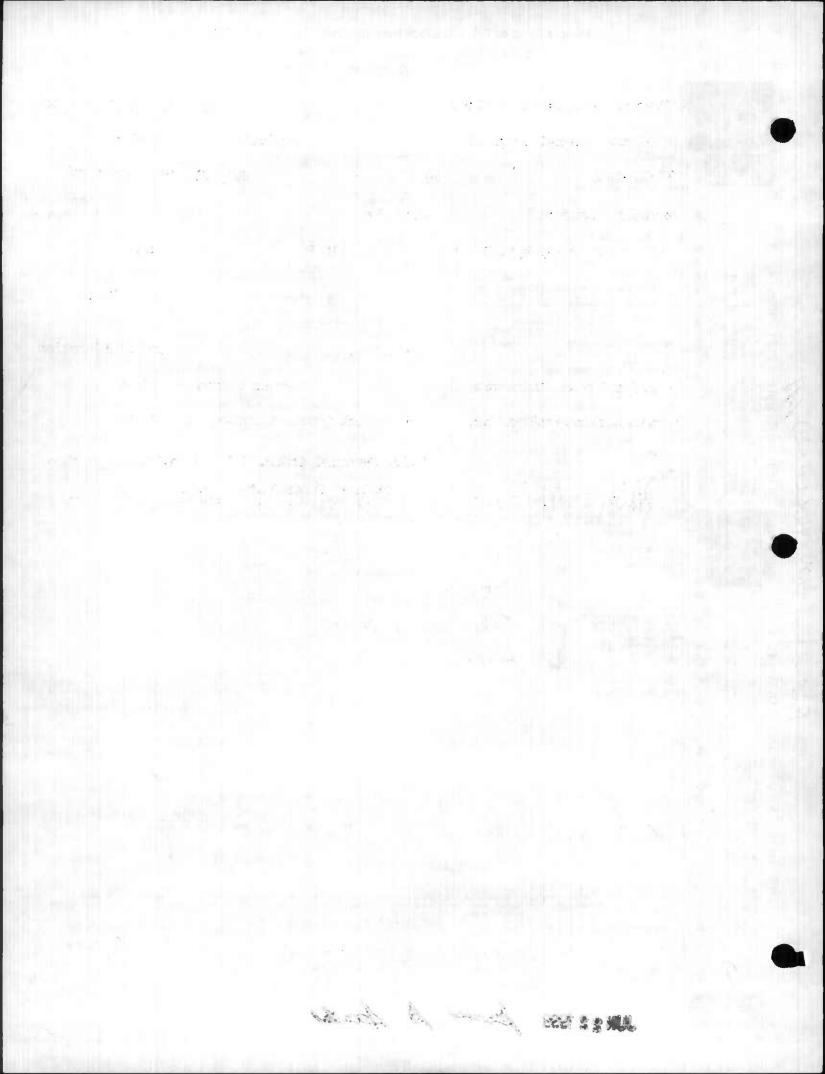
June 19, 1999

MAHMOOD

4-C NORTH AVENUE SUITE 424 BEL AIR

State Registrar





						Cer	tificate of	f Death			Reg. No.		1.0 / 62
		1. Decedent's Ner	me (First, Middle, L.	ast)			11550		5	2. Dete of De Month	eth Dey	Yeer	3. Time of Deeth
Physic /Medi		Dean	na Mich	elle Har	rris					June			7:30 P.M
Exami		4a Facility Neme	(If not institution, gi	ve street end number	er)			4b. City, To	wn, or Lo	ocation of Deal	h 4c. County	y of Death	
@		Harford	Memorial	Hospital				Havre			Harf	ord	
Funeral Director		5. Social Security 210–58–5		Sex 7. 1□ M 2⊠ F	Age (In yrs. las	Yrs.	If Under 1 Yea Months Deys		24 Hrs. Min.	8. Dete of Bi (Month, Di Aug. 2	rth ey, Year) 26, 1963		place (State or Foreign ntry) A
2 *		Usuei Residenca o	of Decedent 10b, County		10c City	Town or Loc	eation						10d. Inside City Limits
e Maryla Ba-f sho diffed at	Director	MD	Harford			e de (	Grace						1X Yes 2□ No
0 5 6 0	Dire	10e. Street and Nu	umber				10f. Zip Code				10g. Citizen of	What Cou	ntry?
33			edom Lane	_		1.0.11	21078			7 N N	USA	an Amend	can Indian.
020 us sher de r, or term xaminer,	by Funeral		rried 2 Married	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	S No		Vas Decedent of Yes, specify Cu ☐ Yes ※ No			Rican, etc.)	Bla	ck, White,	, etc.
Maryland 21215-0020 d2 should be filed within 72 hours at the and Mental Hygiens. The meriked other than "natural", or treatmetic event, the Medical Exam	Completed	(Spe	15. Decedent's E	ducation rade completed)		16a. Deced (Give I life. D	ent's Usuel Occi kind of work don OO NOT use retir	upation le during mos red)	st of work	ing	16b. Kind of B		
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lary 2 sho	10.0	19e. Informent's N	Neme/Reletionship	(Type, Print)							ber, City or Town	, State, Zij	Code)
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altimore, mit. Pages 1 as sortant: If them sortant: If them thighty or other		4 Donation	5 Other (Speci	ify)			Cemeter			/26/99	Havre d	le Gra	æe,MD
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- 10240		Lusa	Scull				552 Lew	is Sti	reet	Havre	de Gra	ce, M	ID 21078
THE REAL PROPERTY.		23a. Part1. Enter shock, or he	the diseese, or corent failure. List only	nplicetions thet cause on each	sed the deeth. h line.	Do not ente	or the mode of d	ying, such es	cardiac	or respiretory	errest,	- !	Approximate Intervel Between Onset and Deeth
Physician /Medical Examiner	Н	Immediete Ceuse diseese or conditi resulting in deeth)	(Finel	· PC	Da.		non	,				- 11	
W =	- a	resulting in deeth)		Λ.	Due to (or	conseq	uenca ot):						week
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ords, P.O. requires that the delean signed by the a	by Phy									1	Yes 20 No	3 □ Pro	obably 4 Unknown
Per red	Completed									24e. We	s en eutopsy ormed?	ev CC	Vere eutopsy tindings veileble prior to ompletion of cause f deeth?
	Eo									10	Yea 2 No	1	□Yes 2DNo
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× · · · · ·	70	examiner?	246	Hospitel:	atient 2 E	R/Outpatien	3□ DOA	Other: 4 N	ursing Ho	ome 5□Res	idence 8 🗆 Ot	her (Speci	ify)
on of Sing Phy After this funeral d		27. Manner of their	5 ☐ Pending	28a Oete of I (Month,	njury Dey Year)	8b. Time of Injury	28c. Inj			28d. Describe	how injury occu	rred	
ide for the function of the fu	cati	2 Modident	investigation	ha				Yes 2	No				
Division  Division  a or Attending  s after death.  It Director: After  a in by the fund	Certification:	4 ☐ Homicide		200. PIECE OF	Injury - At hom etc. (Specify)	ie, ferm, stre	et, fectory, offic	a			(Street end Num own, Stete)	ber or Rur	ral Route Number,
Division o  To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical (	29a. Certifier (Check only one)	Cartifying P 20 Medical Exa	hyaiclan: To the be miner: On the basis and manner	s of examinatio	edge, death n end/or inv	occurred at the estigetion, in my	time, date ar y opinion, dee	nd plece, eth occur	end due to the red et the time	cause(s) end m , date end place	enner as i	stated. to the cause(s)
	M	29b. Signature ag	title of certifier	Leil	-(2		29c. Lice	nse number	9		29d. Date sign	ed (Month,	Dey, Year)
<b>3</b>		30. Neme end edd	dress of parson who	completed cause of	deeth (Item 2	3a) (Type,	Print) Le	Q/L	100	OB	et.	-14	021815
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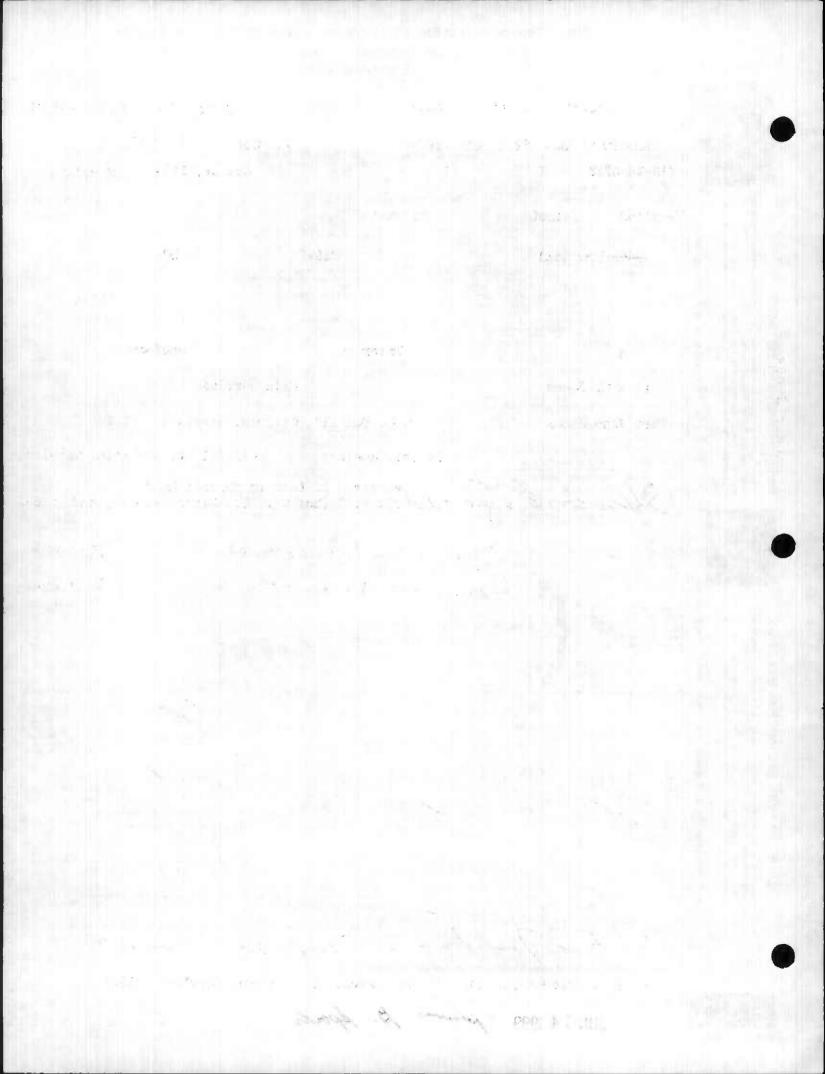


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	#10e, 6/23/99, BRA	, Talbot	•	epartment of Certificate of			Reg. No.	2/3	73
	1. Decedent's Nama (First, Middla, La	est)				2. Date of De			of Death
Physician /Medical	Elbert	Leslie	Jones		4h Cihr Tour	Month June n, or Location of Deat			MA8
Examiner	4a Facility Nama (If not institution, give				_				
5	Memorial Hos		Lasto (In yrs. last birth		r If Under 24	Ston Hrs. 8. Date of Bir	th Ta	1bot 9. Birthplace (Stet	e or Foreio
Funeral Director		X M 2□ F		rs. Months Days	s Hours	Hrs. 8. Date of Bir (Month, De Nov 26,	1924	Marylan	
JII CO.CO.	Usual Rasidence of Decedent					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Wattylo	
show	10a. State 10b. County		10c. City, Town					10d. Inside	
28s-f shonoutied at	Maryland Talb	ot	Wit	tman				1 🗆 Y	as XI N
or 28	10e. Street and Number			10f. Zip Code	0		10g. Citizen of V	Vhat Country?	
234	8448 New Roa	d		21	L676		USA		
r tems 23s or 28s-fs from mart by notified Funeral Director	11. Marital Status	12. Was Dacedant E Armed Forces?	var in U,S.	13. Was Decedent of if Yas, specify Cu	Hispanic Origination, Mexican,	n? (Specify Yes or No Puerto Rican, atc.)	- 14. Raci	e - Amaricen Indian, k, White, etc.	
	1 Never Married Married	1 Yas 2 No	0	1□ Yes 2 No			Specify		
d by	3 Widowed 4 Divorced	Yaar or Dates:						wiiite	
it, the Medical Completed	15. Decadent's E (Specify only highest gro	ducation eda completed)	16a. I	Decedent's Usual Occu 'Give kind of work don' life. DO NOT use retir	upation a during most o	of working	16b. Kind of Bu	usiness/Industry	
than omp	Elementary/Secondery (0-12)	College (1-4or 5-	-)	Waterman	90)		Seafood	4	
vent, the	9 17. Father's Name (First, Middle, Last	n		waternan	19 Mothor	s Name (First, Middle			
traumatic event,		•				a Harrison		10/	
To	Ellis G. Jones		4.01	M. W				Chata Tia Cada)	
rau	19a. informent's Name/Reletionship (			Mailing Address (Street					
	Mary Jane Jones 20a, Method of Disposition	s - Wife		O. Box 11	14, WIL	Date		21676 City or Town, Stata	
or other	Burial 2 Cremation 3	Removal from State	cametery	, cremetory or other pi					
any injury	4 Donetion 5 Other (Special	fy)	Olive	et Cemeter	У	6/14/99	St. Mici	haels, Ma	rylan
deteched for use es the buriel-transit  and the physician Medical Examiner	Immediate Cause (Finel disease or condition rasulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Con	Due to (or as a control of the to (or a) or a control of the to (or a) or a control of the to (or a) or a control of the to (or a) or a control of the to (or a) or a control of the to (or a) or a control of the to (or a) or a control of the to (or a) or a control of the to (or a) or a control of the to (or a) or a control of the to (or a) or a	onsequenca of):	FARCE	707		>(0)	you
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Com						10	Yes 2 No	1 ☐ Yes 2	2□ No
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ertific octor, Be (		Hospital:		patient 3L DOA		sing Homa 5 ☐ Res			
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Ne funeral Director: After this certific pletely filled in by the funeral director edical Certification: To Be	axaminer?  1 Yes 2  27. Manne Death  1 Matural 5 Pending investigation  3 Suicide 6 Could not be determined.  29a. Certifier (Check only one)  29b. Signature and Julie of cadifier	28a. Date of Injun (Month, Day) 28e. Placa of Injun building, etc.  28e. Placa of Injun building, etc.  28e. Placa of Injun building, etc.  28e. Placa of Injun building, etc.	ry - At home, far (Specify)  my knowledge, examination end ed.  ath (Item 23a) (	M 11mm, street, factory, office death occurred at the for investigation, in my 29c. Lice	e time, date and or opinion, deeth	place, end due to the occurred et the time	e cause(s) and me, dete end pleca,	enner es steted. end due to the caus d (Month, Day, Yea	se(s)

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Day 1999 **Physician** JUNE 26, 3:46PM Philip Benedict Joy, Jr. /Medical 4a Facility Nama (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's St. Mary's Hospital Leonardtown If Under 24 Hrs. 8. Date of Birth
(Month, Dey, Year) Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Months Days 10 M 2□ F 48 June 3, 1951 Maryland Director 219-56-0285 Usual Residence of Decedent the Marylend 10a. State 10d, Inside City Limits 10b. County 10c. City. Town or Location retified at 1 ☐ Yas 2 X No Directo Maryland St. Mary's Holl vwood 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? filed within 72 hours efter death with Hygiane. r than "natural", or items 23s or the Medical Experience must be 24525 McIntosh Road 20636 U.S.A. Funeral 12. Was Decedent Ever in U,S.
Armed Forcas?
1 ☐ Yes 2 ☒ No
If Yes, Give Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Biack, Whita, atc. 11 Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify Aq 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Coilege (1-4or 5+) permit. Pages 1 and 2 should be filled wi Department of Health and Mental Hygian Important: if flem 27 is marked other th any injury or other traumatic event, Ing. DDCs. Tavern 9th Owner/Operater 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Meiden Sumeme) Be Philip Benedict Joy, Sr. Margaret Louise Alvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 24525 McIntosh Road, Hollywood, Maryland 20636 Philip B. Joy, III / Son 20b. Place of Disposition (Name of cematery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ABurial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 7/1/99 Leonardtown, Maryland Charles Memorial Gardens 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. lardener P.O. Box 270, Leonardtown, Maryland 20650 23a. Part1. Enter the disease, of complications that caused the deeth. On not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** My DEARCHAL INFARETION Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to for es a consequence of Physician/Medical Examiner certificate be executed physician and the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Dua to (or as a consequence of) esn 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 1 Yee 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy irector, page 2 s Division of Vital Physician: 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) To Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No DOA Aftar this 28a. Date of injury (Month, Dey Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: or Attending 1 Natural 2 Accident 5 Pending invastigation 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Straet and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 T Homicide A 24 house the Funeral Direction 1 Certifying Phyelclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 hor To the Fune completaly fi 29d. Date signed (Month, Day, Year) 29b. Signature and litter of certifier 29c. License number 14285 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. WILLIAM D. BOYD II LEONARDTOWN, MD. 20650

Registrar

31. Date filed (Month, Dey, Yeer)

JUN 2 9 1999

32. Regiştrar's Signature

Service of the servic

March 1997 and the state of the

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death June 19, 1999 **Physician** Rosemary (nmn) 0430 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Harford Memorial Hospital Havre de Grace Harford | H Under 1 Yaar | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | Sept. | 16, 1927 | New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Months 71 Yrs. Director 091-20-1438 Usual Residence of Deceden the Marylenc 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits "naturel", or items 23s or 28s-f show 1 Yas 200No Directo Maryland Harford Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with USA death Funeral 2905 Rolling Green Dr. 21028 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 210 No If Yes, Giva Year or Dates: Was Dacedant of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, Whita, atc. 72 hours after 1 Never Married 2 Married 1 Yes 2√2 No Specify: Specify: White þ 3√2 Widowed 4 □ Divorced Hygiene. other than "nature ent, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within tent of Health end Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Research & Development other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be peyrem Daniel August John Susie P. Maribato 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cog. 9528 Estate Cottage, Unit BO7 Christiansted 19a. Informent's Neme/Relationship (Type, Print) Health om 27 i John P. Karr / Son St. Croix, VI 00821

20b. Piece of Disposition (Name of cemetery, crematory or other plece) or other Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Arlington National Cem. 6-28-99 Arlington, Virginia 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatury of Fun and Sarvice Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway Street, Bel Air, MD 21014 hon that caused the death. Do not enter the moda of dying, such as cardiac or raspiratory arrest, cause on each line. 23a. ert1. Entar the disease, or complica shock, or heart failure. List only on Approximate Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 1915 Examiner Due to (or as a consequence of): Examiner verre Ł Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) physician s the buriel La Physician/Medical Ses ettending for usa as eaks signed by the e Part II. Other significant conditions contributing to beath but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Division of Vital Records, P. P 24b. Were autopsy findings avaliable prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 2 certificate hes 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) To. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2☑ No 1 Inpatient 2 ER/Outpetient 3 DOA funeral 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28h Time of 28c. Injury et Work? Certification: 1 ☑ Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation efter deat Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 6 To the Hospital or within 24 hours eft To the Funeral Di complataly filled in 29a. Certifier Medical (Check only one) and manner stated. 29d. Data signed (Month, Day, Year) 29b. Signature and file of cert 29c. Licensa number cause of deeth (Item 23e) (Type, Print) Name and address of person Aho co 308 Feygues 110 31. Date filed (Month, Day, Year) 32 Registrar's Signature JUN 2 2 1999 Registrar

**DHMH 16 Rev 6/95** 

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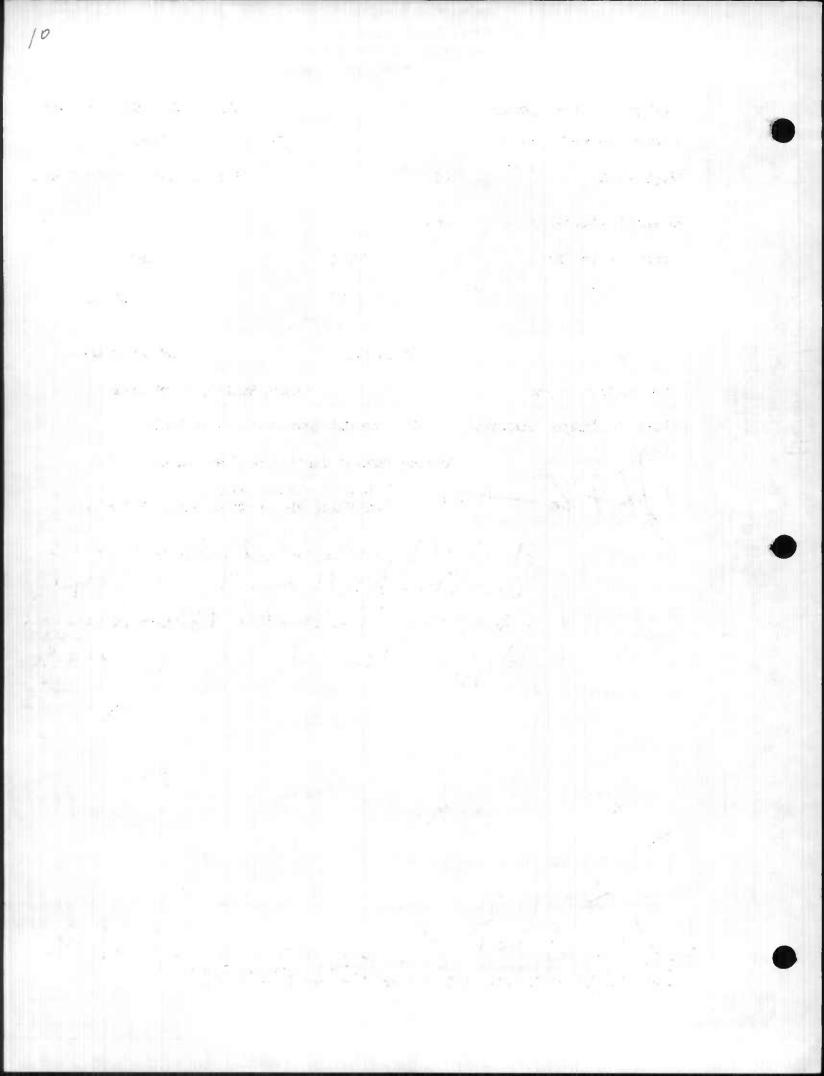
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Counth 1. Decedent's Name (First, Middle, Last) Month Year **Physician** June 1999 22 0:55pm HELEN LORRAINE KLINGER /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Civista Medical Center LaPlata Charles If Under 24 Hrs. Hours Min. 5. Sociel Security Number 7. Age (In yrs. last birthdey) If Under 1 Year Birthplace (Stete or Foreign Country) 8. Date of Birth (Month, Dev. Year) **Funeral** Months Days 1 M 25 F Director SEPT 17 1934 Pennsylvania 161-28-7889 with the Meryland 10c. City, Town or Location 10d Inside City Limits 10a State 10h Counts ortant: if item 27 is marked other than "netural", or items 23s or 28s-4 show injury or other treumstic event, the Mapical Examples must be notified at 1 ☐ Yes 2 No Directo Maryland Charles Marbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 5660 New Cut Road 20658 USA deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White ρ 3 ☐ Widowed 4 ☐ Divorced end Mentel Hygiene. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) US Government Accounting 17. Fether's Neme (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Heelth and Mentel Hyg Important: If Item 27 is marker eny Injury or 18. Mother's Name (First, Middle, Meiden Sumame) Be 2 Bertha Schleig Hornberger George Hornberger 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dean E. Klinger (Husband) 5660 New Cut Road Marbury, MD 20658 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Batial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Trinity Memoral Gardens 6-25-99 Waldorf, MD o of Auneral 21. Sign 22. Name and Address of Facility J.H. Eberwein Mortuary 741 asse, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, MD 20695 Approximete re. List only one cause on each line. M00173 Interval Between Onset end Deeth **Physician** x Has /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last buriel-tran and requires that the death certificate be exec physician s the buriel Division of Vital Records, P.O. Box 68760 Physician/Medicai usa as 1 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the cause of death? been signed by the should be detached 3 Probably 4 Unknown 1 ☐ Y## 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed paga 2 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate or Attending Physician: funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 ER/Outpatient 3 DOA 2 1 Inpatient this 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred Manyfer of Death 28b. Time of 28c. Injury at Work? Certification: After Natural 2 Accident 5 Pending deeth. 1 ☐ Yes 2 ☐ No investigation after deeti Director: 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Hospital ertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es steted.

Discretifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier completely To the Vithin 2 29d. Date signed (Month, Dey, Year) License number 29b. Signature and title of certifier 20629 30. Mar d address of person who completed cause of deeth (Item 23a) (Type, Print) 11345 Pembrooke Square Wathen, MD Suite 103, Waldorf, Maryland 20603 George H. 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature State **JUN 24** 

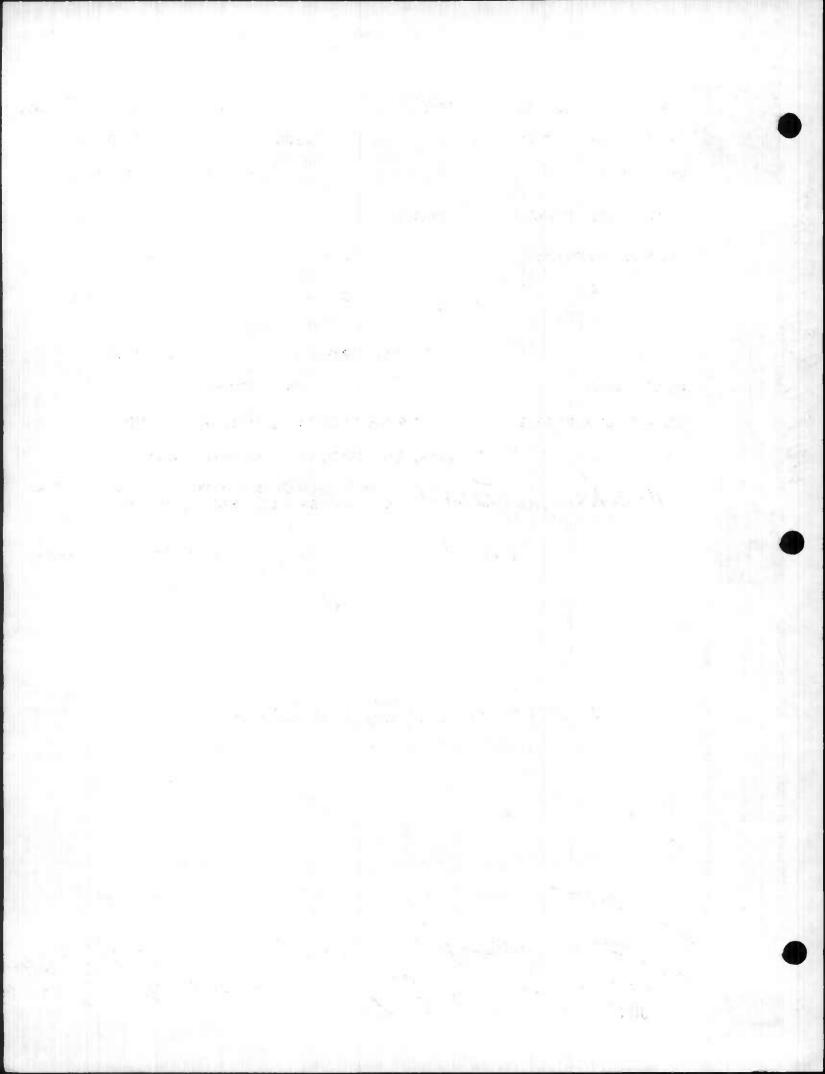
Registrar **DHMH 16 Rev 6/95** 

1999

Helen Klinge



	Certificate of Death		Reg. No.		
ciar dica	RURERT EMMETT LAVERY	2. Date of Dea	Day Day	Vear	Time of Death
nei	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or L	ocation of Death		nty of Deeth	OP.C
	DOCTORS COMMUNITY HOSPITAL  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year if Under 24 Hrs.	8 Date of Birt		ICE GEOR	
ı	496-14-0771 1\(\text{X}\) M 2□ F 77 Yrs. Months Deys Hours Min.	8. Date of Birt (Month, De NOV • 30	y, Year) 1921	Country) ILLIN	(State or Foreig
	Usual Residence of Decedent				
	10a. State 10b. County 10c. City, Town or Location SEABROOK				Inside City Limits
1	FID FRINCE GEORGES SEADROOK				
ċ	10e. Street and Number  10f. Zip Code			of What Country?	
Eliperal Director	9329 WELLINGTON ST. 20706  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispenic Origin? (Sp	pecify Yes or No-	US 14. Re	ace - American I	ndien.
hy Eur		Rican, etc.)		lack, White, etc.	ITE
hot	15. Decedent's Education  16a. Decedent's Usual Occupation  Considerable and a semiclated	k la a	16b. Kind of	Business/indust	ry
Completed	(Specify only highest grade completed)  (Give kind of work done during most of work life. DO NOT use retired)	King			
				NTING	
a	17. Father's Name (First, Middle, Last)  18. Mother's Nam  FELTX LAVERY  AGNES	BUTLER	Melden Sume	eme)	
F			or City or Tow	m State 7in Co.	dol
	19e. Informent's Neme/Relationship (Type, Print)  BETTY M. LAVERY/ WIFE  19b. Mailing Address (Street end Number or Ru  9329 WELLINGTON ST.,				Je)
	20a. Method of Disposition 20b. Piace of Disposition (Name of	Date		n - City or Town,	Stete
	1 ☑ Burlai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)	6-24-99			
	21. Signature of Funeral Service Licensee				
	FELLOWS, HELFENBEI				ME, P.A
r	200 S. HARRISON ST  23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one ceuse on each line.	or respiratory ar	rest	Ap	proximate
ı	Shock, of real failure. Elst only one cause of each line.	/	//	On	erval Between set and Death
	Immediate Cause (Final disease or condition (a Y C I nom a	· la	uns	3	week
,	resulting in death)  a. Due to (or as a consequence of):		/		No.
Examiner	• b		-		
XAR	Sequentially list conditions, if any, leading to immediate			1	
dical F	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet Initiated events			- 4	
- C	resulting in death) Lest				
Physician/M	<b>d</b>			-	
gicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Party	23b. Dfd t	lobacco usa c	contribute to the	cause of deal
Phy	Coronam artem dise	200 10	Yes 2□ No	3 Probabl	y 4 Unkno
2	control of court	200	KIDS	0.11.	
Completed			an autopsy med?	availat	autopsy findings ble prior to ation of cause
mp					etion of cause th?
		101	/\	1 □ Y€	s 2□No
980				When /Or - 24 '	
n: To	1 28 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing H	ome 5 Resid			
Cartification:	Netural 5 Pending (Month, Day Year) Injury Work?  2 Accident Investigation M 1 Yes 2 No				
Hifics	3 ☐ Sulcide 6 ☐ Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tox	Street and Nun	mber or Rural Ro	oute Number,
Can	building, etc. (Specify)	July Of TON	Giale/		
edical		and due to the	cause(s) and r	manner as state	d. cause(s)
De					
ァ	29c. License number	/	Date sign	ned (Month) Dey	(Year)
2	NO OF T				
M	mid \$ 028920	2 . /	10.	21/1	199
M	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	b.	16.	2111	199 :
te	30. Name and address of person who completed cause of deady (Item 23a) (Type, Print)  UR INDER  31. Date filed (Month, Dey, Year)  JUN 2 2 1999	er Par	tuay	2) M	199 eenbe D; 20



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L	Amended	it	em 31, 06-25-99,S		iai yiai i	_	tificate of		ı Mentai Hy	Reg. No.	-	1.0.100	
		an	1. Decedent's Nema (First, Middla, L						2. Data of Dea	Day	Yaar	3. Tima of Death	
	/Medi	al	EDITH MYRTLI  4a. Facility Nama (If not institution, gi			LONG		4h City Town o	JUNE or Location of Death	25 199 4c. County		12:30 AM	
-	Examir	er	201 HALL HIGHWAY			R		CRISE			RSET		
	Funeral Director		5. Social Security Number 6. 218-16-5007				If Undar 1 Yaar Months Days			9. Bir C ,1918 MAJ		lace (Stata or Foreign try) LAND	
	and		Usual Rasidance of Dacedant  10a. Stata 10b. County		10c. City	ty, Town or Location					11	10d. Insida City Limits	
	the Marylan r 28a-f show	tor	MD SOME	RSET	C	RISFIE	LD					1 X Yas 2 □ No	
	or 284	Director	10e. Street and Number		-		10f. Zip Coda			10g. Citizen of W	hat Coun	try?	
020	eth w	ral	201 HALL HIGHWA				2181			USA			
	72 hours efter deeth with the Maryland natural', or items 23a or 28a-f show final Examinal mant be notified at	by Funeral	11. Marital Status  1 □ Nevar Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedant Armed Forces 1  Yas 2 If Yas, Giva Yaar or Datas:	Forces? If Yas, specify Cubar 2 ☑ No Giva 1 ☐ Yas 2 ☑ No				14. Race - Amarican Indian, Black, Whita, atc.  Specify: WHITE				
5-0		eted	15. Decedent's 8 (Specify only highast gi	ducation ada complated)		16a. Deced	ant'a Uaual Occu kind of work dona	pation during most of w	rorking	16b. Kind of Bu	alnass/Inc	iustry	
121	A Paris	To Be Completed	Elementery/Secondery (0-12)	College (1-4or 5+)		(Giva kind of work dona during most of wo lifa. DO NOT usa retired)  HOMEMAKER				OUN F	OWN HOME		
d 2	should be filed vand Mental Hygie		17. Fathar's Name (First, Middla, Las	1)		HOTTE	IAKLK	18. Mothar's N	ama (First, Middla,				
Baltimore, Maryland 21215-0020	should be nd Menta marked umatic ev		JAMES HENRY CLOU	JGH		NANCY		NANCY	MYRTLE SPARKS				
	d 2 the 7 ls		19a. Informant's Name/Ralationship G. COLEY LONG /				-		Ru <i>ral Route N</i> umbe HESTERTOW		. ,	Code)	
	of Ha If item or oth		20e. Mathod of Disposition 1 ☐ Burial 2 【 Cramation 3 [	Ramoval from Stata	CE	ama <i>t</i> a <i>ry, cre</i> m	ition (Nama of atory or other pla		Data	20c. Location - (	1		
	tment tant:		4 □ Donation 5 □ Other (Spec	fy)	CHE				6-25-99	STEVENS	VILL	E, MD	
Bal	permit. Pages 1 an Department of Haal Important: If item 2 any Injury or other once.		21. Signature of Funaral Samue Lice	Mun ?	Lit	FE		ELFENBE	IN & NEWN			OME, P.A.	
	-		23a. Part1. Entar tha diseasa, or con shock, or haart failura. List only	nplications that cause ona causa on aach	d tha daath ina.	. Do not anta	r tha moda of dyi	ng, such as card	iac or raspiratory at	rest,		Approximata Interval Between Onsat and Death	
	Physician /Medical Examiner		Immediata Causa (Final disaasa or condition rasulting in daeth)	a. 13110	itus	L Pr	reumon	ia			1	,	
		-e	accurry we decay		Due to (or	r es a consequ	uanca of):					2 days	
	and Fransit	al Examiner	Sequantially list conditions.	b. Pulmanay columa.  Due to (or as a consequence of):							- 1	201-195.	
60,			Sequantially list conditions, if any, laading to immadiate cause. Enter Undarlying Cause (Diseasa or Injury	C							į		
68760,	phys the	edical	that Initiated avants rasulting in death) Last	Dua to (or as a consaquence of):									
	nding use a	Completed by Physician/Me											
	o o o		Part II. Other significant conditions	contributing to death but not rasulting In tha undarlying cause givan in Part I.					23b. Dld 1	23b. Did tobacco use contribute to the cause of death?			
Records, P.O. Box	thet the ed by detac		1 Yes 2 No 3 Probably 4 Unknown									pably 4 ☐ Unknown	
	aw requir		24a. Was an autopsy performad?								ava	ara autopsy findings allabla prior to mplation of causa daeth?	
	The ate h	Com							10	as 20(No	1 🗆	Yas 2□ No	
Vita	Physician: The this certificate ral director, pag	Be	25. Was casa referred to madical axaminar?	26. Plece of Death (Check only one)									
of Vital	shys this al di	7: To	1 ☐ Yas 2 No 27. Manner of Deeth							a 5 ☐ Rasidanca 6 ☐ Othar (Specify)  8d. Dascribe how injury occurred			
ion	nding J eth. r: Aftar ne funer	atior	1 Neturel 5 Panding invastigation	(Month, Day Year)		Injury Wor		rk? ]Yas 2∐No					
Division	of or Attending F setter deeth. I Director: After d in by the funer	Certification:	3 ☐ Suicida 6 ☐ Could not I 4 ☐ Homicida determined	28a. Plece of Injury - At home, farm, streat, factory, office building, etc. (Spacify)					28f. Location (S City or Tox	28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)			
	To the Hospital or Attendit within 24 hours efter deeth. To the Funeral Director: A completely filled in by the fu	edical C	29a. Cartifiar (Check only one) Certifying P	hysician: To the best miner: On the basis of and manner si	of exeminati	viedga, daath ion and/or inv	occurred at the ti astigation, in my	me, date end ple opinion, death oc	ce, end due to tha curred at the tima,	ceusa(s) and mai data and pieca, a	nner as st nd due to	eted. the ceuse(s)	
	To the To the	Me	29b. Signatura and titla pf cartifiar	/			29c. Licen	sa number		29d. Data signed	(Month,	Day, Year)	
			2 MINDR	. USHA N	ATTESA	N .	De	51389		6/25/	99.		
			30. Nama and addrass of person who					45.0.0.10					
			DR-USHAUN SAT	uuu	rar's Signat	tau.			LUPIELD	(MD 2	1817	-	
	Sta Registr			9 1000	Leve	va	B. 1	na Val					

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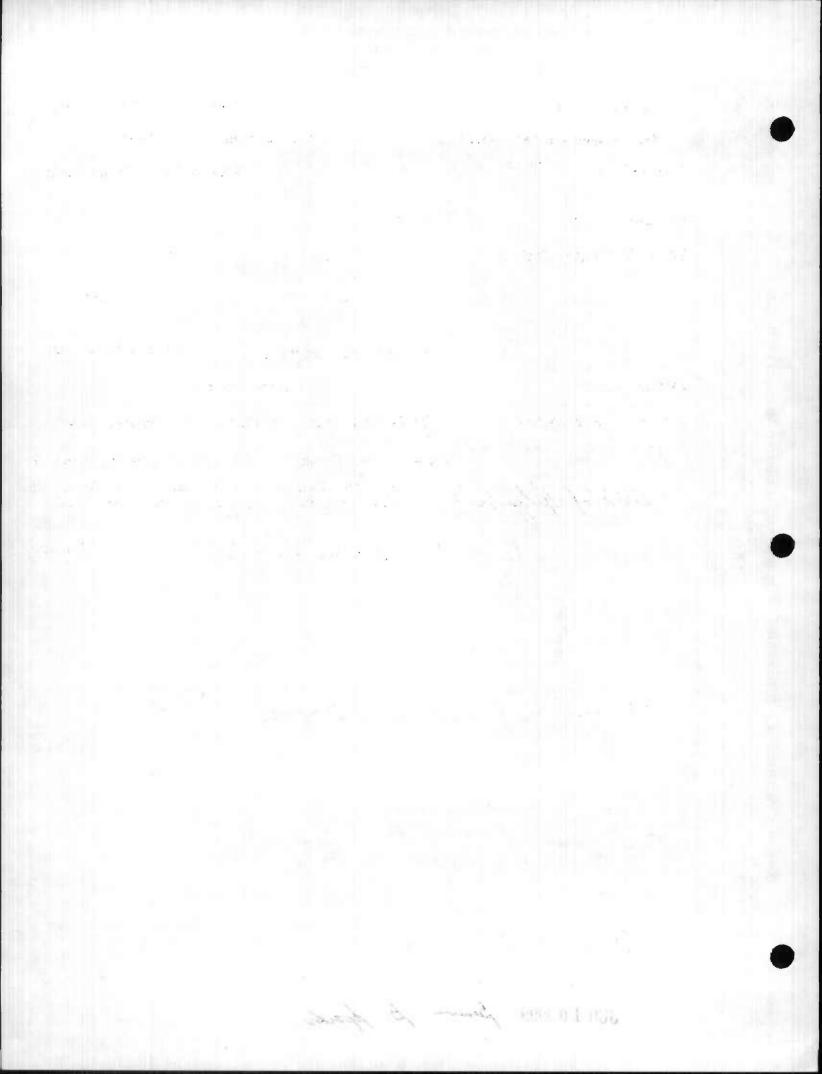
-					•		tificate o	of Death		Reg. No.	W 50	1912		
Phy:	sicia	an l	Decedent's Name (First, Middla, Last)						2. Date of D Month	eath Day	Year	3. Time of Death		
	edic	-	Edgar D. Lusby									6:55 am		
Exa	min	er	4a. Facility Nama (If not institution, give		. /-			4b. City, Town, or						
			11500 Kennedyville Road (Residence) Kenned 5. Social Sacurity Number   6. Sax   7. Age (In yrs. last birthday)   If Under 1 Yaar   If Under 24 Hrs.							<del>-</del>				
Fune Direct	_		216-36-8185 XXXM 2 F 97 Yrs. Months Days Hours Min.							2, Year)	01 Ce	cilton, M		
land			Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loc	ation		10d. Inside City Limits					
death with the Maryland ms 23a or 28a-f show		P	Maryland Kent Kennedyv									1 ☐ Yes 20XNo		
r 28a		Director	10e. Straet and Number				10f. Zip Code			10g. Citizan	of What Count	ry?		
h wit			11500 Kennedyv:	ille Roa	А			21645			II.S.A			
		Funeral		12. Was Decedent E Armed Forces?		. 13. W	as Decedent o	of Hispanic Orlgin? ( uban, Mexican, Pue	Specify Yas or N	0- 14.1				
ary land 21215-UUZU should be filed within 72 hours efter death with the Marylan nd Mentel Hygiene. marked other than "natural", or items 23s or 28s-1 show		þ	1 ☐ Navar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	☐ Yes 21 No Yes, Give		1 ☐ Yes 2X□Xio Specify:							
2-C		Completed	15. Decedent's Edu	cation		16a. Decede	ent's Usual Occ	cupation	adela a	16b. Kind o	f Business/Ind	ustry		
within within then "r		npie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. D	(Give kind of work done during most of working life. DO NOT use retired)							
ygien t		Con	8				/ & Gr	Grain Farmer				re		
VIANG 2  Vuld be filed  Mentel Hygi  Irked other  atic event.		Be	17. Father's Name (First, Middla, Last)						me (First, Middle		3. Time of Dea  1999 6:55 an  Country of Death  Kent  9. Birthplace (State or For Country), 10d. Inside City Lir 1 Yes 20  can of Whal Country?  U.S.A.  14. Race - Amarican Indian, Black, White, etc.  Specify: White  Ind of Business/Industry  Ciculture  Sumeme)  On  Town, Stete, Zip Code)  216  edyville, Maryla cation - City or Town, State  medyville, Maryla cation - City or Town, State  medyville, Maryla cation - City or Town, State  Interval Between Onsat and Death  24b. Were eutopsy findin available prior to completion of cause of deeth?  1 Yes 2 No  3 Probebly 4 Unkr  sy  24b. Were eutopsy findin available prior to completion of cause of deeth?  1 Yes 2 No  3 Other (Specify) y occurred  4 Number or Rural Route Number, and manner as stated. place, and dive to the cause(s)  a signed (Month, Day, Year)  a signed (Month, Day, Year)			
should by and Mente marked marked		2	James Z. Lusby						lma Rob			016/1		
2000			19a. Informant's Name/Relationship (Type		/5.7.					_				
e, and least the man		-	20a. Method of Disposition	etn Lusb	-		ition (Name of		Date Date					
nor of no			XXBurial 2 ☐ Cremation 3 ☐ R	emoval from State	cen	netery, crem	atory or other p	olace)						
baltimor semit. Peges Separtment of I mportant: If ite		-	4 Donation 5 Other (Specify) Shrewsbury Cemetery/June 18, 1999 Kennedyville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility											
Dallimor permit. Pages Department of H Important: If ite any injury or of	once.	1	W/2 18 1	11/20		Fe]	lows,	Helfenbei						
			23a. Part1. Enter the disease, or compli- shock, or heart ailure. List only on	cations that caused	the death.	PO not ente	Box 27	O, Millin	gton, Ma	aryland	21651			
Physicia	an		shock, or heart failure. List only on	e cause on each line	θ.			,		,		Interval Between Onsat and Death		
/Medic	ai		Immediate Cause (Final disease or condition resulting in death)  a. Cardio pulcuovary Annast  Due to (or as a consequence of):  Myorardia Tufarctini											
Examin	er		resulting in death) a		Due to (or a	as a consequ	ance of):	1 1111						
P #		Examiner		L	uso	carole	inf I	refact	zai					
cete be executed physician end sthe buriel-trensit		хаш			Duello (or a	s a consequ	ence of):	0						
be ex			Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury											
oor ou, ifficete be executed g physician end es the buriel-trensit		edical	thet initieted events resulting in death) Last	0	oue to (or a	s a consequ	enca of):				i			
din din	1		d											
death ce		Physician/M	Day II Ohara day district						005 014	23b. Did tobacco use contribute to the cause of death?				
the cythe ache		hys	C . A	onditions contributing to death but not resulting in the underlying ceuse given in Part I.				given in Part I.			/			
s that	1	by P	Jemle Dementia											
faw requires that the se been signed by the 2 should be detached.	:	8								24e. Wes en eutopsy performed?  24b. Were eutopsy findings available prior to				
faw re		Completed							poi	omiou.	con	npletion of cause		
The The gate he page		E							1 🗆	Yes 2 HN	0 1 🗆	Yes 2□ No		
vital necessician: The faw securificate hes to difficate her di		Be	25. Was casa referred to medical axaminar?					26. Place of De	ath (Check only	ona)				
Physic this ce rai dire	,	0	1 ☐ Yes 2 ☑ No H	ospital: 1 🗆 Inpatien	t 2 EF	R/Outpatient	- 3 DOA	Other: 4 Nursing	Home 5 Hes	ome 5 ☐ Residence 6 ☐ Other (Specify)				
ng P		00	27. Manner of Daath  1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day	Year)	8b. Time of Injury	28c. In	jury at Vork?	28d. Describe	how Injury oc	curred			
Jeath. Ior: A	1	cat	2 ☐ Accident Investigation 3 ☐ Suicida 6 ☐ Could not be	rone				☐ Yes 2 ☐ No						
al or Attending s effer death. I Director: After od in by the fune		Certification:	4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 Homicide						28f. Location (Streat and Number or Rural Route Number, City or Town, Stete)					
To the Hospital or Attending Physician: within 24 hours effer death.  To the Funeral Director: After this certific, completely filled in by the funeral director,		edical	29a. Certifier  (Check only one)											
o the	:	-	29b. Signature and title of certifies	wing mainter state	0		29c. Lice	ense number		29d. Date slg	gned (Month, E	Jay, Year)		
- s + ō			30. Name end eddress of person who completed cause of deeth (item 23a) (Type, Print)  To line Uning The M. W. O. 948 unis lining from 1970.  31. Date flips (Month, Day, Year)  32. Registrar's Signature											
	1	5	30. Name end eddress of person who cor	mpleted cause of risk	eth (item 2	3a) (Tvna P	rint)	- 7 0 /		1011	1111	-		
			Tolune unnasm	con mi	0 9	741	unslu	ing trun 1.	Tre 10	us dert	om Ule	12/020		
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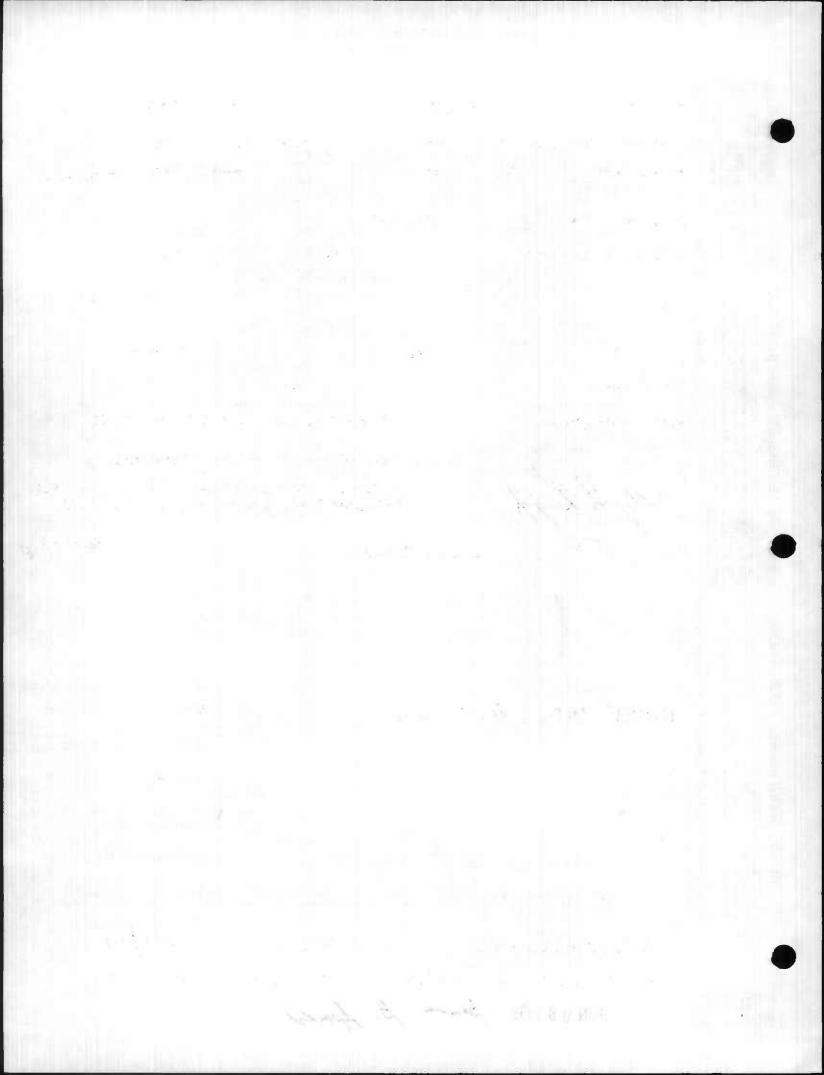
	1. Decedent's Name	(First, Middle	, Last)					2. Date of De		3. Tima of Death
ician	Pieter	Lente	rs					Month June	7 199	
dical niner	4a Facility Name (If			m <i>ber</i> )			4b. City, Town, or L			
IIIIIEI	Kent &	Oueen	Anne's H	ospital	L		Chestert	own	Kent	
al	5. Social Security Nu		6. Sex	7. Age (In yrs.		If Under 1 Yea	if Under 24 Hrs.	8 Date of Bir		Birthplace (Stete or Fore Country)
or	091-16-575	54	11XM 2□ F	87	Yrs.	Months Day	Houra Min.	July 2	2 1911 Ne	etherlands
	Usual Residence of 10a. Stata	Decedent 10b. County		100 C	ity, Town or Lo	cation				10d. Inside City Limi
ሯ										1 Yas 2 1
ect	Maryland  10e. Street and Num	Kent		R	ock Hal	10f. Zip Code			10g. Citizen of What	t Country?
Funeral Director	22030 Harı		Dark Do	hod			.661			
era	11. Maritai Status	LINGCOL	12. Was Dec	edant Evar in L	J,S. 13. V		Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No	USA - 14. Race - A	Amarican Indian,
by Fur	1 Never Marrie		ed 1 Tas If Yes, Gi Yaar or D	Z/XNo		f Yes, specity Cu 1 ☐ Yes 2000N		Rican, etc.)	Specify:	White, atc. White
Be Completed		15. Decedent	's Education		16a. Deced	lent's Usuai Occ	upation e during most of work	daa	16b. Kind of Busine	ass/Industry
ple	Etementary/Secon		t grede complated) College (	1-4or 5+)	life. L	DO NOT use reti	ed) most or work	ung		
Con	12		4		1st Ma	ate on F	reighter			Transport
Be	17. Father's Name (		Last)						Maiden Sumame)	
2	Herman Ler		in Chart City		104 11:00	a Address (O)	Neeltje			to Zin Codel
	19a. Informant's Na Pieter Ler						et end Number or Ru			
	20a. Method of Disp		ebuew	20b.	Ptace of Dispo-	sition (Neme of	urt, Hami	Date Date	ot. Canada 20c. Location - City	
		Cramation	3 Removal from	State		netory or other p			D- 1 77 3	7 1/ 7
	21. Signature of Fur		1117	we		napel Ce		5/10/99	Rock Hal	1, Maryland
	The second secon		-1	15	Tr.	11	TT 1 C 1. 2	n & Newr	nam Funera	al Home, P.
	23a, Part1, Enter th	e disease or	omplications that	aused the dea	th. Do not ente	30 Speer	Road, Che ying, such as cardiac	estertov or respiratory a	m, Maryla	and 21620
	shock, or hear	f failure. List o	only ope dause on e	each line.						Interval Between Onset and Death
	Immediata Causa (F	Final	Pro	state (	Gnces	with	i me to	tere		4 year
	resulting in death)		a	Dua to (	or as a conseq					
ine			<b>b</b>							
edical Examiner	Sequentially list con if any, leading to im- cause. Entar Undar	nditions, mediate		Dua to (	or as a conseq	uence of):				
<u>e</u>	cause. Entar Undar Cause (Disaase or in that initiated events	injury (	c							İ
edic	resulting in death) L	ast		Dua to (	or as a conseq	uance of):				
M		,	d							
Physician/M	Part II. Other signific	cant condition	ns contributing to d	aath but not re	sulting in the ur	nderlying cause	given in Part I.	23b. Did	tobacco use contril	buta to the cause of dea
5	A		notic (				5000	10	Yes 20 No 31	Probably 4 Unkn
유	111101	. ,	2010	and, 8	Too au	or P.	2.026			
by									an autopsy 2 ormed?	<ol> <li>Wara autopsy findin available prior to completion of cause</li> </ol>
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by									Yes 2 110	1 ☐ Yes 2 ☐ No
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Be Completed by	25. Was case referrence examinar?	•	Hospitat:	2_			26. Placa of Dea	th (Check only	ona)	- 11-11
To Be Completed by	examinar?	NO			ER/Outpatien	I 3L DOA	Othar: 4 Nursing H	th (Check only o	ona) denca 6 Other (	Specify)
To Be Completed by	examinar? 1 Yes 227  27. Manner of Death 1 Natural	No No 1 5 □ Pending	28a. Date		ER/Outpatien	28c. In	Othar: 4 Nursing H	th (Check only o	ona)	Specify)
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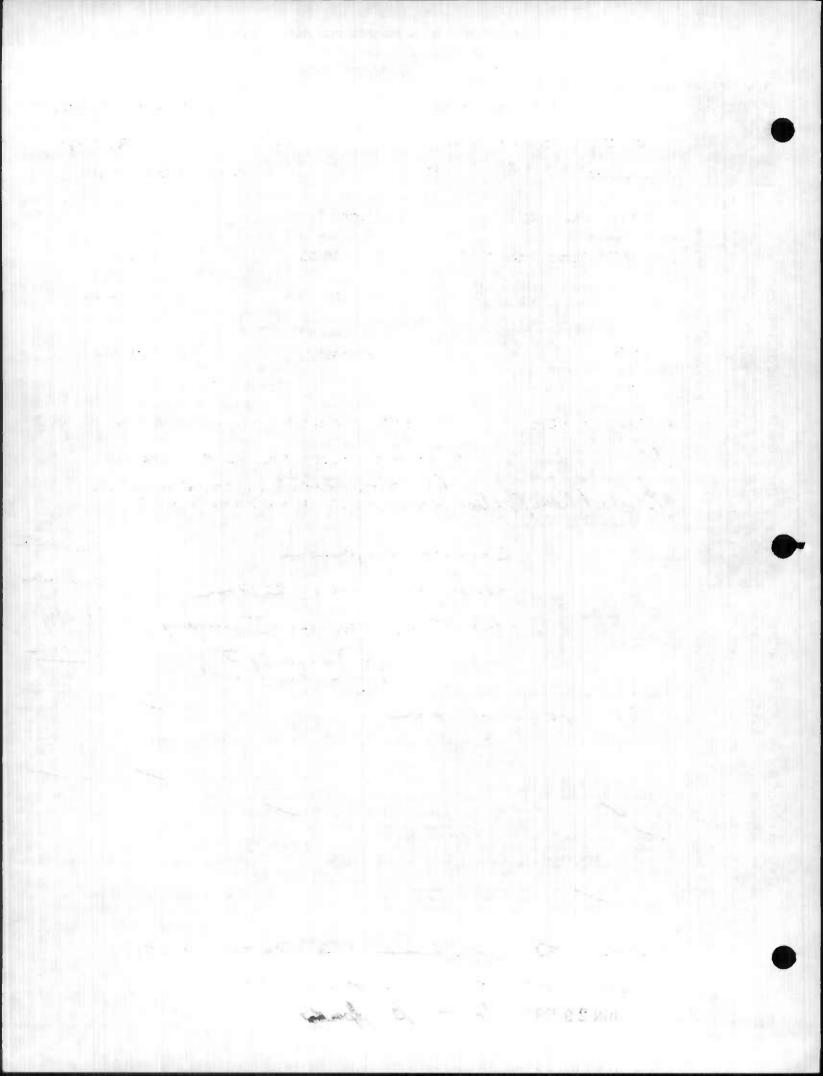


State of Maryland / Department of Health and Mental Hygiene

Physician Medical Examiner    Eleanor   Four field production   Four field pro						Ce	rtificate	of	Death			Reg. No.		91	
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30. Name and address of person who completed cause of death (Item 23e) (Type, Print)  Nei (Staddord WD 100 Brown St. Chestortown WD 2620	Hospital of 24 hours at Europeal D	etely filled i	(Check only 2 Medical	Examiner: On the basis	of exemination	ige, deet end/or in	h occurred et	the tir	ne, dete en pinion, des	nd pleca, oth occurr	end due to the ed et the time,	cause(s) date end	end mar placa, e	ner as si	teted. the ceuse(s)
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an al	Ell		Letta	u				Month	26, 199	Yaar 9	4:55 A
	4a Fscility Nama (If not institution, given	a street and number	)				4b. City, Town, o	or Location of De	ath 4c. County	of Death	
	St. Mary's N 5. Social Security Number 6. S 216-36-6040		ga (In yrs.	last birthday).	If Undar Months	1 Yaar Days	Lennard If Undar 24 H Hours Mi	rs. 8. Data of E	Sirth Day, Year) 19, 1916		Mary's place (Stata or For
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	19a. Informant's Name/Ralationship (	Type, Print)		19b. Mailin	ng Addrass	(Street	and Numbar or	Rural Routa Nun	ber, City or Town,	Stata, Zip	Code)
	William Lettau/S	on		1833	5 Thr	ee i	Notch Ro	oad, Lex	ington Pa	ark,	MD 20653
	20a. Mathod of Disposition		20b. P	laca of Dispo-	sition (Nan	ma of	ce)	Data	20c. Location	City or To	own, Stata
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X	30. Nama and address of person who	completed cause Air	daath (Itan	23a) (Tune	Print)					-6-/-	
	30. Nama and addrass of person who					rdto	wn, MD	20650			



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM #30 PER DVR G774 8/20/99 AH Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death **Physician** Month Robert Cobourn Lawder June 21 1999 5:20pm /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rising Sun C
if Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Calvert Manor Healthcare Center Cecil 5. Social Security Number 6. Sex If Undar 1 Yaar Birthplace (State or Foreign Country)
 MD 7. Aga (In yrs. last birthday) **Funeral** 1**X** M 2□ F Months Days Yrs. Director 82 218-10-8101 04/05/1917 Usual Rasidance of Decedan the Maryland 10a Stata 10b County 10c. City, Town or Location 10d. Insida City Limits "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 X Yas 2 □ No Director Harford Havre de Grace 10a, Street and Number 10f. Zip Coda 10g. Citizan of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Hatilh and Mental Hydiona.

Department of Hatilh and Mental Hydiona.

The many injury or other traumatic event, the Medical Exercise, must be not any injury or other traumatic event, the Medical Exercise (must be not any injury or other traumatic event, the Medical Exercise. USA 966 Chesapeake Drive Funeral 21078 12. Was Decedant Evar in U,S. Armad Forcas? 1X1 Yas 2 D No If Yas, Giva Year or Datas: WW 2 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Navar Married 2 ☐ Married 1 ☐ Yas 2 X No Specify: þ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 18a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 4 years Supervisor Internal Revenue Serv. 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Surnama) Be Robert R. Lawder Helen M. Cobourn 19e. Informant's Name/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 2. Elwood Stark- Personal Rep. 30 Office St. Bel Air, MD 21014 20a. Mathod of Disposition 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 1 XBurial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) Angel Hill Cemetery 6/26/99 Havre de Grace, MD 21. Signature of Funaral Service Licensee 22. Nama and Addrass of Facility Mitchell-Smith Funeral Home, P.A. 23a. Fart. Entar tha disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, mack, or heart failure. List only one cause on each line. ) 123 S. Washington, Havre de Grace, MD 21078 Approximata Interval Between Onset and Death **Physician** /Medical fmmediata Causa (Final disaasa or condition rasulting in death) . METASTATIC SARCOMA of @ LUNG 1998 Examiner Dua to (or as a consequence of): RIMARY SITE SARCOMA OF OMENTUM Examiner 1996 law requires that the death certificate be axecuted physician and s the burlat-transit Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disaase or Injury that initiated events rasulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequence of): signed by the a Part If. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown NON-INSULIN DEPENDENT DIABETES MEHITUS Completed by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Hyper Tension 2 8 No 1 ☐ Yas 2 ☐ No certificata 1 ☐ Yas Hospital or Attending Physician: director, 25. Was case rafarred to medical axaminar? Be 28. Place of Death (Check only one) Hospital: 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA Aftar this 28a. Data of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Tima of fnjury 28c. Injury et Work? 28d. Dascribe how Injury occurred 5 Panding invastigation Netural s after death. 1 Tas 2 No 2 Accident 6 Could not be determined 3 ☐ Suicida 24 hours after de
 Funeral Directo
lataly filled in by the 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospi within 24 hou To the Funer complately fil 29a, Cartifier 1 🔁 Certifying Phyalcian: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. Medical (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of certifiar 29c. Licensa number 29d. Data signed (Month, Day, Year) Mus 30. Nama and address of person who complated causa of death (Itom 23a) (Type, Print)

State Registrar MALCOLM D PHILLIPS
31. Data filed (Month, Day, Year)

JUN 2 3 1999

32. Registrer's Signatura

CALVERT MANOR HEAETH CARE CENTER

Sports

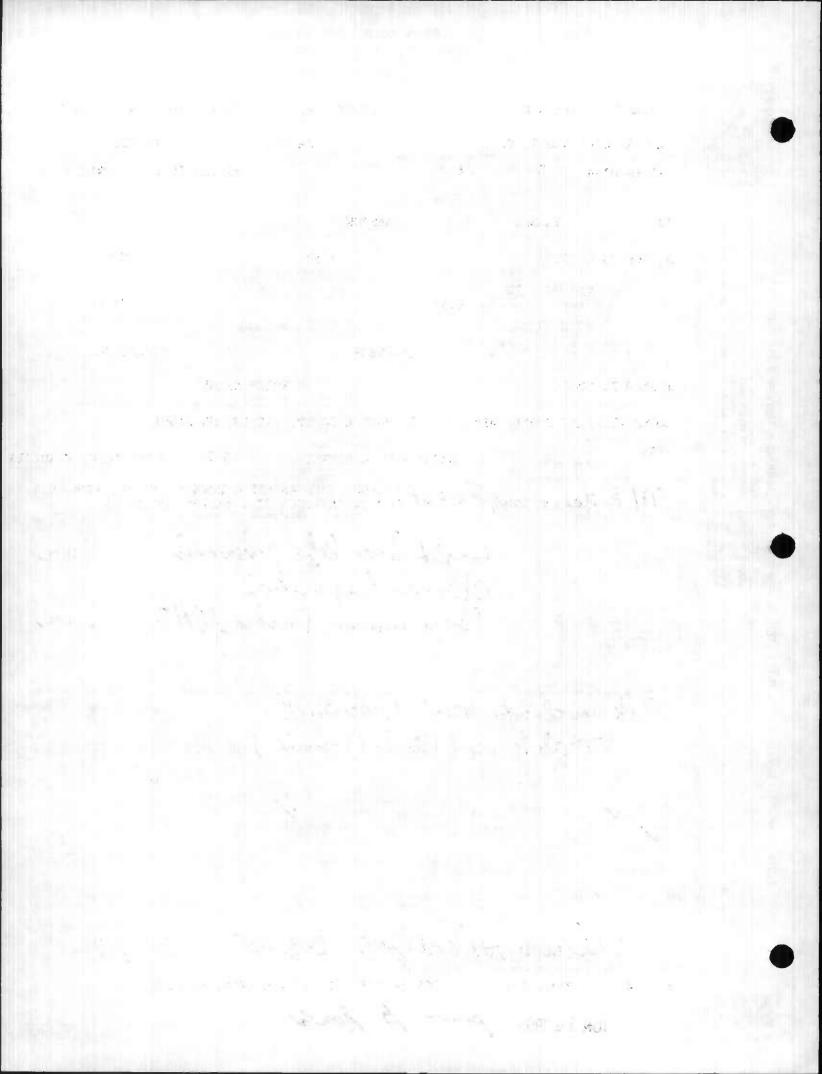
2017 TRAPPE CHURCH RD, DARLINGTON, MD

THE RESIDENCE OF THE PROPERTY OF THE PARTY O

State of Maryland / Department of Health and Mental Hygiene

					iai y iai ia	Cei	rtificate o	f Death		Reg. No.	
		1. Decedent's Nam	e (First, Middle, La	st)					2. Date of De Month		3. Time of Death
	Physician /Medical	JOSEPH	FRAN	CIS			MOORE,	JR.	JUNE	10, 199	
	Examiner	4a Facility Name (I	f not institution, giv	e street and number	r)				r Location of Death	4c. County of	
Ø.		WILLIAM	HILL HEA	LTH CARE				EASTON		TALBO	T
	Funeral Director	5. Societ Security N 463-16-0	lumber 6. S	Sex 7. A	nge (in yrs. last	t birthday) Yrs.	Months Day	ar If Under 24 Hr			D. Birthplace (State or Foreign Country) VIRGINIA
D		Usuel Residence of									
rylen	whow I	10a. State	10b. County		10c. City, T	Fown or Lo	ocation				10d. Inside City Limits
Σ	cto	MD	TA	LBOT		E	ASTON				1 Y Yes 2 □ No
£	or 28	10e. Street and Nur	mber				10f. Zip Code			10g. Citizen of Wh	at Country?
th wi	23a	36 HUNTI	ER COURT				2	1601		J	JSA
dea	The res	11. Marital Stetus		12. Was Deceden	t Ever in U,S.	13.	Was Decedent o	t Hispenic Origin? Joan, Mexican, Pue	(Specify Yes or No	- 14. Race -	American Indian, White, etc.
d 21215-0020 filed within 72 hours efter death with the Marylend	th and Mental Hygiena. 7 le marked other than "naturel", or itema 23a or 28a-f show traumatic event, the Medical Experiment must be notified at To Be Completed by Funeral Director	3 Widowed	ied AMarried 4 Divorced	1XX es 2 If Yes, Give Year or Dates	] No		1□Yes 2₩X			Specify: V	
2 50	hygiena. her than "nature nt, tre wed call Completed	10	15. Decedent's E		1	16a. Dece	dent's Usual Occ	upation ne during most of w	ndina	16b. Kind of Busin	ness/Industry
215 hin 7	pie di	Elementary/Seco	oify only highest gra	College (1-4o	r 5+)	life.	DO NOT use ret	red)	Orking		
2 P	or the	12		4		ENGI	NEER			PETROI	LEUM
Pu a	d other event, t Be Cc	17. Father's Name		)						, Maiden Sumame)	
/an	Menta prrked atice	JOSEPH I	F. MOORE					EDIT	TH RIXEY		
Maryland	amp amp	19a. informant's Na	ame/Relationship (	Type, Print)		19b. Mailir	ng Address (Stre	et and Number or	Rural Route Numb	er, City or Town, St	ate, Zip Code)
C	Health and 27 li	LLOYD W	ILLIAMS M	OORE/ WIF	E	36 H	HUNTER C	OURT, EAS	STON, MD	21601	
more	ont of nt: If its y or o			Removal from Stat	e cem	etery, crer	osition (Name of matory or other p		Date 6-15-99	20c. Location - Ci	ity or Town, State VILLE, VIRGINIA
Ph ./I	ysician Medical caminer	Immediete Ceuse disease or conditio resulting in death)	(Finel n	plications that cause one cause on each	ed the death. line.	20	00 S. HA	RRISON ST	EASTO	N. MD 216	AL HOME, P.A.  601 Approximate Interval Behvelen Onset and Death  //// /// // // // // // // // // // /
P.O. Box 68760, hat the deeth certificate be assecuted	igned by the attending physician and be detached for use as the bunat-trensit by Physician/Medical Examir	Sequentially list co if any, leeding to in cause. Enter Unde Cause (Disease or that initiated events resulting in death)	Last	contributing to death	Due so for in			given in Part L			ribute to the cause of death?
Division of Vital Records, P.O. Box Ior Attending Physicien: The law requires that the deeth cert	should should		impl	ete le	ant B	erch	(Pac	eneaher,		ormed?	24b. Were autopsy tindings available prior to completion of cause of death?
ita	stor.	25. Was case reter	red to medical					26. Place of D	eath (Check only	one)	
> oley	his ce al direc	examiner?	No	Hospital: 1 Inpa	tient 2 EF	R/Outpatie	nt 3 DOA	Other: 4 Nursing	Home 5 Res	dence 6 Other	(Specify)
0 5	ner th	27. Manner of Deat		28a. Dete of In (Month, L	jury 28	Bb. Time o	28c. Ir	njury at Vork?	28d. Describe	how injury occurred	t
io in life	r: Aff	1 Matural 2 Accident	5 Pending investigation	n	, , , , , ,	,,		☐Yes 2☐No			
Divis	irs aftar deeth.  I Director: After tilled in by tha funera Certification:	3 Suicide 4 Homicide	6 Could not be determined	Zoe. Place of I	njury - At home etc. (Specify)	e, farm, st	reet, factory, office	ca	28t. Location ( City or To	Street and Number wn, State)	r or Rural Route Number,
• Hospita	within 24 hours after deeth.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2  Medical Certification: To Be Comp	29a. Certifier (Check only one)	1 Certifying Pt	nysician: To the bes minar: On the basis and manner:	ot examinetion	edge, deat n and/or in	h occurred at the	time, date and pla y opinion, deeth oc	ce, and due to the curred at the time,	cause(s) and many date end place, an	ner as steted. nd due to the cause(s)
di o	Fo the	29b. Signature and	title of confined	. /	P	110	29c. Lice	ense number		29d. Date signed	(Month, Day, Year)
	7.	<b>&gt;</b> 1	NULLIA	m H	1,1000	ech	MSD	DOR 71	5	6/11	199
		30. Name and adds	ass of parson who	completed cause of	death (Item 2	38) dune	Print)	0-07.		4/11	
				, JR., M.				VENIIE E	A CITONI AIT	21601	
	State	31. Date tiled (Mon			strar's Signatur		EWILD A	VENUE, El	ADION, MIL	21001	
	Registrar			N 4			4 6				

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1999 CHARLES ALBERT MATTHEWS 31 11:50AM March /Medical 4a Facility Nama (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Easton The Memorial Hospital # Under 24 Hrs. Houra Min. 6. Sex 1 M 2 □ F If U-r 8. Date of Birth (Month, Day, Year) 9. Birthpiaca (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Houra Months Days Yrs. MAR.16, 1910 89 MARYLAND 214-32-6768 Director Usual Residence of Decedent with the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Modical Examinat must be not fied at 1 ☐ Yes 2 Wo MD EASTON TALBOT Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 7218 MAXMORE CREEK DRIVE 21601 Funeral filed within 72 hours after death 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 X No Specify: WHITE þ 3 Widowed 4 Divorced Completed 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16e. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I Hygiena. Coilege (1-4or 5+) Elementary/Secondary (0-12) PLUMBING MECHANICAL CONTRACTOR 11 18. Mother's Name (First, Middle, Maidan Surname) 17. Father'a Name (First, Middle, Last) 80 h and Mental h GEORGIANNA PORTER JAMES F. MATTHEWS Pagas 1 and 2 should 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health a Important: If fram 27 is any injury or other traugung. P.O. BOX 190, EASTON, MD 21601 MILDRED C. MATTHEWS/ SPOUSE altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1X Buriai 2 ☐ Cremation 3 ☐ Removal from State SPRING HILL CEMETERY 4-5-99 EASTON, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona causa on each line. Approximate Interval Between Onset and Death **Physician** Immediata Causa (Final disease or condition rasulting in daath) /Medical pirator Examiner twe Pulmonary Prseau Examiner physician and s tha bunal-transit law requires that the death cartificate be executed Sequentially list conditiona, if any, laading to immadiata cause. Entar Underlying Cause (Disease or Injury that injuried aways or Injury) Due to (or aa a consequence of) Box 68760. Physician/Medical that initiated events Due to (or as a consequence of). resulting in death) Last 88 usa ed by the a 23b. Did tobacco use contributa to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 0 42 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably ۵ signed t Records, þ 24e. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed peen completion of cause of death? cartificata has Tha 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Daath (Chack only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funaral 28a. Dete of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Tima of 28c. Injury at Work? Certification: Aftar or Attending 1 Naturai 5 Pending within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homiclde Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

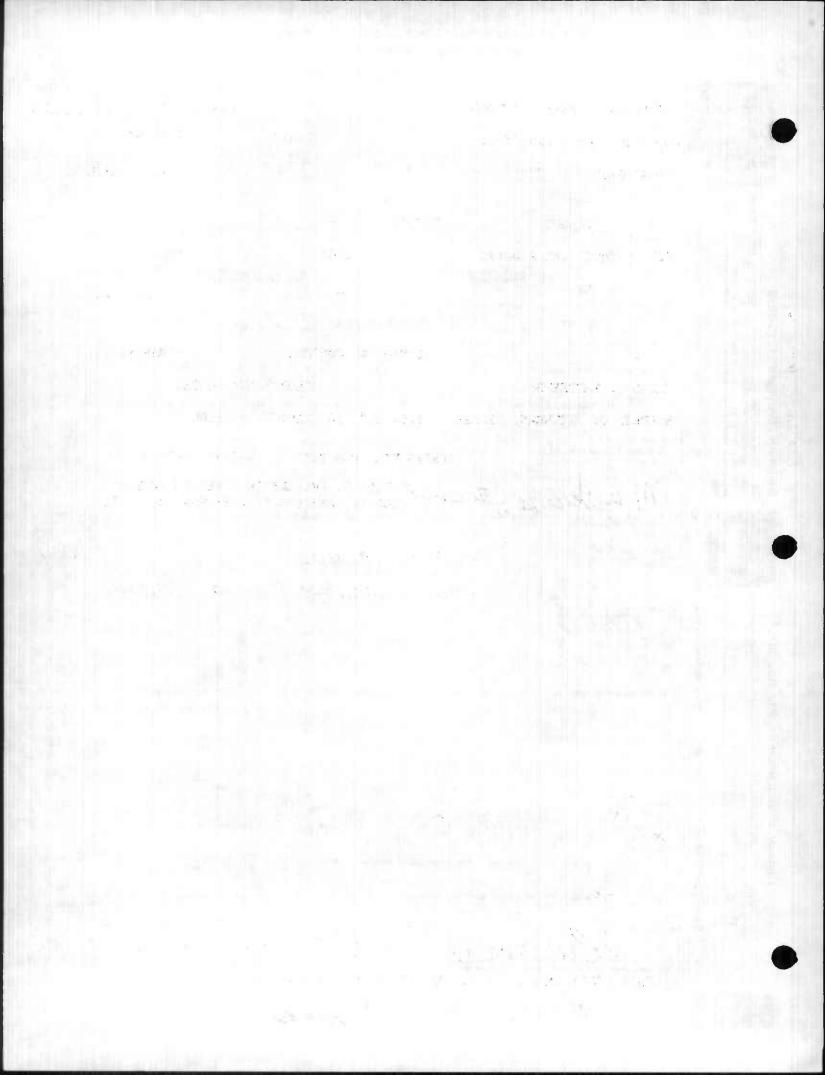
| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Cartifia (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature end title of cartifie 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

State Registra

31. Date filed (Month, Day, Year) APR 0 2 32. Ragistrar's Signature 1999

CYNTHIA RUBIO, M.D., 216 S. WASHINGTON ST., EASTON, MD 21601

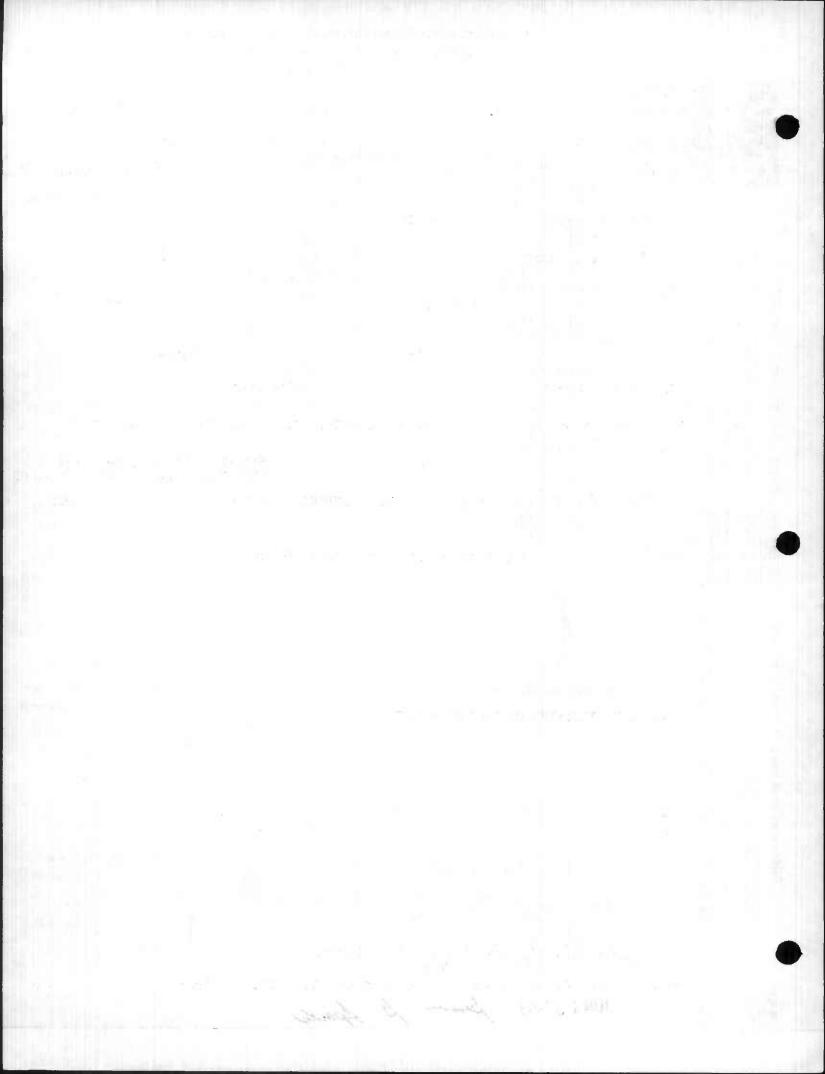
Albert Matthews



State of Maryland / Department of Health and Mental Hygiene

					•	Ce	ertifica	te of	Death	R	eg. No.		
	-		1. Decedent's Nema (First, Middle, Li	ist)						2. Dete of Dee	th		. Time of Deeth
į.	Physic		CLARENCE	S				MO	ORE	Month 06	Dey 12	Yeer 99 1	121
	/Medi Examir		4a. Facility Nama (If not institution, gi	e street end number	)			- 10	4b. City, Town, or		4c. County		
	LAGITIT	161	22367 CAPITOLA RI						TYASKIN		WICOM	rco	
	Funeral				ge (In yrs.	lest birthdey		r 1 Yeer	If Under 24 Hrs	8. Dete of Birth			(State or Foreign
	Director		212-18-0328 Usuel Residence of Decedent	1⊠M 2□F	76	Yrs.	Months	Days	Hours Min.	(Month, Dey April 7	, 1923	Country)	gton, D.C
	f show	o.	10e. Stete 10b. County			y, Town or L	ocation.						Inside City Limits
	28a-	Director	Maryland Wicomic	:0	l y	askin	106.7	p Code			Og. Citizen of V	Mat Country?	
	th with 23e or		22367 Capitola F	load				1865			USA	viiet Country?	
0	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylend Depertment of Health and Mentel Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumetic event, tra Medical Examinst must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married	12. Wes Decedent Armed Forcas 1 X Yes 2 If If Yes, Give	? No		If Yas, sp	ecity Cut	Hispanic Origin? (Span, Maxican, Puan Specify:	pecify Yas or No- o Rican, atc.)		e - American Ir k, White, etc.	ndian,
21215-0020	ral',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Detes:	1944-	46	100	22110	оросиј.		Эреспу	BLACK	
2-(	72 h natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16e. Dece	edent's Us	el Occu	petion during most of wo	rkina	16b. Kind of Bu	isiness/industr	У
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Maryland	of the A	Be	17. Fether's Name (First, Middle, Las	)						ma (First, Middle,	Meiden Sumem	10)	
/la	Vent Vent rrked	To	Clarence D. Moor	e					Helen I	DeNeal			
an	ampa me	ľ	19e. Informent's Neme/Reletionship	Type, Print)		19b. Mail	ling Addres	s (Stree	t end Number or Ri	ural Route Numbe	r, City or Town,	Stete, Zip Coo	de)
Σ	1 and 2 Health e em 27 is		Astor Moore/broth	er		1524	0qde	n St	., N.W.	- Washing	ton, D	.c. 200	010
re	of He		20e. Method of Disposition			Plece of Displantage	osition (Ne	me of			20c. Location -		
Ĕ	Peges nent of h ant: If ite ury or of		1 ☑ Burlet 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Speci		1	V.A.		•	1	/16/99	Hurlock	. Marv	land
Baltimore,	ertm ortan		21. Signature of Funerel Sarvice Lice		TID								isbury, M
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	_	$\vdash$	23a. Pert1. Enter tha disaasa, or con shock, or heart failure. List only	nolication, that cause	d the deat				MORIAL CH		ast.	And	21801 proximete
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final	U								On	ervel Between set and Death
	Examiner		disaasa or condition resulting in deeth)	e HYPERT	ENSIV	E CARI	AVOIC	SCUL	AR DISEAS	SE			
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o.	0 0 2	ysi	Part II. Other significant conditions	contributing to death	but not res	ulting in the	underlying	cause g	iven in Pert I.				cause of death?
S, D.	The law requires that the de ale hes been signed by the e page 2 should be detached i	by Ph	CHRONIC OBSTRUCT	VE PULMON	ARY I	DISEAS	E			101	′es 2∐ No	3 Probabl	y 4⊠Unknown
ğ	ulres t									24e. Wes		24b. Were e	eutopsy findings
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<u> </u>	Physician: The ratio contilicate and director, pag	Be	25. Was casa referred to medical exeminer?	Hospitel:			-	O	A. A.	ath (Check only o			
of	5 00	2	1 X Yes 2 No 27. Menner of Deeth	1 Li Inpat		ER/Outpetie 28b. Time		ΨA	4 C Hallang	lome 5 AResid			
L C	ding h. After fune	lon	1 Neturel 5 Pending	28a. Date of In (Month, D	ey Year)	injury	М	28c. Inju	ork? ]Yes 2∐No	20d. Describe in	ow injury occur	160	
Sign	Attending Physical Attention of the funeral by the funeral	cat	2 Accident Investigetion 3 Suicide 6 Could not I							28f. Location (S	troot and Numb	or or Pural Po	outo Alumbar
Division of Vital	P # 2 =	Certification:	4 ☐ Homicide determined	28e. Plece of Ir building, e	itc. (Specif	ome, tarm, s y)	treet, racto	гу, опісе		City or Tow		ei oi nuiai no	ible Wollber,
	To the Hospital or within 24 hours effe To the Funeral Dir completely filled in		29e. Certifier 1 Certifying P	nysician: To the besi		uladas das	th convers	d at the t	ime date and pleas	and due to the	souss(s) and me		d
	Hos 24 hr Fun etely	edical		miner: On the basis on menner s	of exemine	tion end/or l	nvestigetlo	n, in my	opinion, deeth occi	urred at the time,	date and plece,	and due to the	cause(s)
	ithin o the	Me	29b. Signature and title of certifier				2	ec. Licen	sa number		29d. Data signe	d (Month, Dey	; Year)
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			30. Neme and eddress of person who							030	0.7		
			JOHN T. BULKELEY  31. Dete filed (Month, Day, Year)		8 PIN Var's Signe		FF RC	AD,	SALISBUR	X WD 518	OT		
	Sta Registr		JUN 1 5	1999	Japer		4	la					

Registrar



State of Maryland / Department of Health and Mental Hygiene

						Ce	ertifica	te of	Death	F	leg. No.			
	DI -1-1-1-		1. Decedent's Name (First, Middle,	Last)						2. Date of Dea Month	th Dey	Year	3. Tim	ne of Deeth
	Physicia: /Medica	_	Loui	ise Ann Mei	ster					June		999	11:	30pm
	Examine	- 1	4a Fecility Name (If not institution, §		)				4b. City, Town, or I	Location of Deeth	4c. County	of Death	7.5	
100			7473 Swan Point	Way					Columbia			Howar	rd	
	Funeral Director		5. Social Security Number 6 6 6 9 - 32 - 9446	5. Sex 7. Ag 1  M 2	ge (In yrs. 59	last birthday Yrs.	) If Und Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Feb 18,	1940	9. Birthp Coun On 1	itry)	ate or Foreign
	P .		Usuel Residence of Decedent		140- 0	T1							04 11	de Otto I locato
	show		10a. State 10b. County			ty, Town or L						1		de City Limits Yes 2 No
	Ba-f	0 1	Maryland Howard	d		Columb	_							TOO LEFITO
	death with the Maryland me 23a or 28a-f show		10e. Street and Number					ip Code			10g. Citizen of V	Vhet Cour	itry?	
	23a	a '	7473 Swan Point					2104			Unite			
21215-0020	urs after	by rur	11. Marital Status  2 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces'd 1 ②Yes 2 ☐ If Yes, Give Year or Dates:	?	,S. 13.	was Dec If Yes, sp 1□ Yes		lispenic Origin? (S an, Mexican, Puert Specify:	pecity Yes or No- o Rican, etc.)	Specify	ea - Americok, White, Whi	etc.	n,
2-0	72 ho	Ted	15. Decedent's (Specify only highest)			16e. Dece	edent's Us	ual Occup	etion	rkina	16b. Kind of Bu	usiness/Ind	dustry	
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Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 Is marks any injury or other treumatic once.		21. Signature of Funeral Servica Lic	ansee - C	20	Jes H	arry	H. W	ess of Fecility itzke's I olumbia I	Family Fi	uneral i	Home,	Ind	21043
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	Physician		shock, or neert tailure. List or	ily one cause on eech i	line.							1	Onset	Between and Death
	/Medical		Immediate Cause (Final disease or condition	a	Gner	alis	d	Car	Ci a nonc	Mac.		1	1	mth
	Examiner	9	resulting in death)	в	Due to (	or as a conse	equence of	:):		70301				
Н	70 ==	Je			neto	asta	6.	bre	ci noma	cancer			6	mins
	nd	E	Sequentially list conditions,	D		or as a conse						i		
0,	e axe ian a uriel-		Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury		bro	aet	ca	nce	~				7	years
68760,	rificate be axecuted ng physician and as the buriel-transit	Ö	that initiated events resulting in death) Lest	C	Due to (d	or es e conse			0 142 1					
	ing p			■ d										
Вох	tend or us	22		- u.		22.700								
	the a	Physicianim	Part II. Other significant conditions	contributing to death t	but not res	ulting in the	underlying	ceuse giv	ven in Pert I.	23b. Dld t	obacco use co	ntribute to	the ca	use of death?
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Records,	law requires that the death certificate be assecuted as been signed by the attending physician and 2 should be detached for use as the buriel-transit	ted bal									an autopsy	ev	allable p	
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E E	Physician: The law rthis certificate has rral director, page 2	3		1522						101	es 25€No	1[	☐ Yes	2 No
<u>Sit</u>	clan	0	25. Was case referred to medical exeminer?	Hospital:				0		ath (Check only o				
5	hysi this o	0	1 ☐ Yes 2 No	Hospital: 1 Inpati		ER/Outpatie		JUA		fome 5 Aesic			y)	
L C	Ing P	- CO	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Dete of Inju (Month, Da	ay Year)	28b. Time Injury		28c. Inju		28d. Describe h	low injury occur	rea		
Sic	tend death tor: /	Car	2 Accident investigat 3 Suicide 6 Could no	t ho	-1. A. b.		M		Yes 2□No	28f. Location (5	Street and Alumi	har or Rus	al Pouto	Alumbar
Division of Vital	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	4 ☐ Homicide determine	ed 288. Pieca of in building, e	tc. (Speci	fy)				City or Tow	m, Stete)			redinoer,
	Hospi 24 hou Funer letaly fill		29a. Certifier (Check only one) Continue Check only (Check only one)	Physician: To the best caminer: On the besis of and manner st	of exemina	owledge, dee ation and/or i	th occurre nvestigation	d et the ti	me, date and place opinion, death occu	e, end due to the curred et the time,	ceuse(s) end madate and placa,	anner es s and due t	teted. o the car	use(s)
	ro th rithin comp		29b. Signature and title of cartifier				2	9c. Licens	se number		29d. Dete signe	d (Month,	Day, Ye	iar)
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Physician /Medica Examine

**Funeral Director** 

permit. Pages 1 end 2 should be filed within 72 hours after death with the Merylend Department of Haalth and Mantal Hygiane. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, or a Medical Examiner must be notified at ODGs.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.

To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

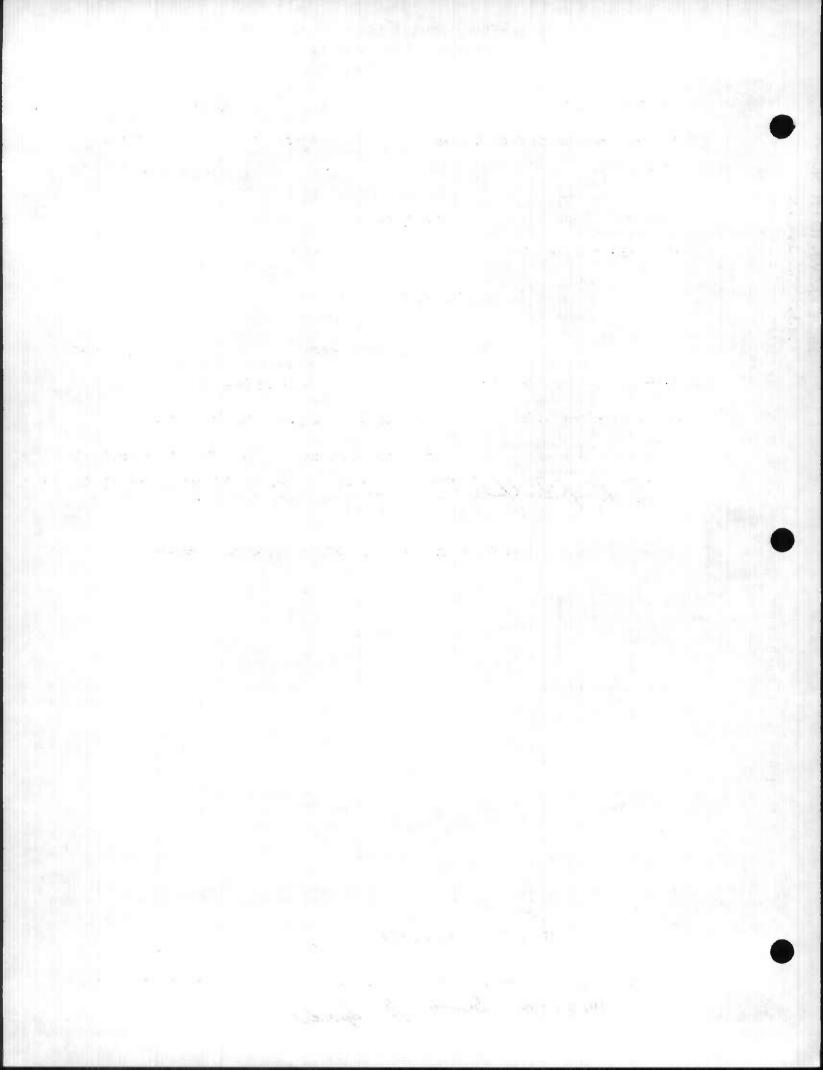
Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0029

Please Type or Print in Black Indelible Ink.	Assure All Coples Are Legible.
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				Cei	rtificate of	Death			Reg. No.		
I. Decedent's Name (Firs		ist)					2.	Dete of Dee Month	eth Dey	Year	3. Time of Death
James Nicho	1son						Jı	une 20			8:40 A.M
a Facility Name (If not it	nstitution, giv	e street and nu	imber)			4b. City, Town	n, or Locati	lon of Death	4c. County	of Death	
VA Maryland	Healt	th Care	System	n		Perry	Point	t		ecil	3,517
. Social Security Number	r 6. S	Sex		s. last birthday)	If Under 1 Year Months Days		Hrs. 8.	Date of Birt (Month, Day arch 8	h V Yearl		place (State or Foreig
220-28-0484	1	1 <b>X</b> M 2□ F	6	6 Yrs.	WORKING Days	Hours	Ma	irch 8	, 1933	Stil	1 Pond, MI
Jsual Residence of Dece	dent										
I Oe. State 10b.	County		10c. C	City, Town or Lo	ocation						10d. Inside City Limit
Maryland	Kent			Crumpto	on						1 ☐ Yes ŽQŽN
IOe. Street and Number					10f. Zip Code				10g. Citizen ot V	Vhat Cou	intry?
1510 Dudley	Corne	r Road			2	21628		-	USA		
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	error de de contra de	Armed Fo	orces?	0,0.	It Yes, specify Cub	an, Mexican, I	Puerto Ric	an, etc.)		k, White	
1 Never Married 2	* ** *	1 X Yes If Yes, Gi	ive 105	0-1954	1□ Yes 2NNo	Specify:			Specify	. Wh	ite
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Elementary/Secondary		College (		life.	DO NOT use retire	9d)					
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7. Father's Name (First,	Middle, Last)	)				18. Mother's	Name (F	irst, Middle,	Maiden Sumam		
Benjamin F.	Nicho	lson. S	Sr.			Mary	Hickm	nan			
19a. tntormant's Name/R			,	19b. Maili	ng Address (Street				er, City or Town.	State. Zi	ip Code)
Helen Nicho		,,									
		TIC	201-		ox 25, Cr	umpron		Date	20c. Location -	Clhyor T	own State
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4 Donation 5 0			S	still Po	ond Cemet	ery	6/2	3/99	Still 1	Pond	, MD
21. Signature of Funeral	- 11	2/ 1	Pe5	_ F	ellows,	Halfon'	bein Ches	& New	nam Fune	eral 216	Home, P.
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disease or condition			stage C		Obstruct:						Interval Between Onset and Death
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29c. License number 1026350

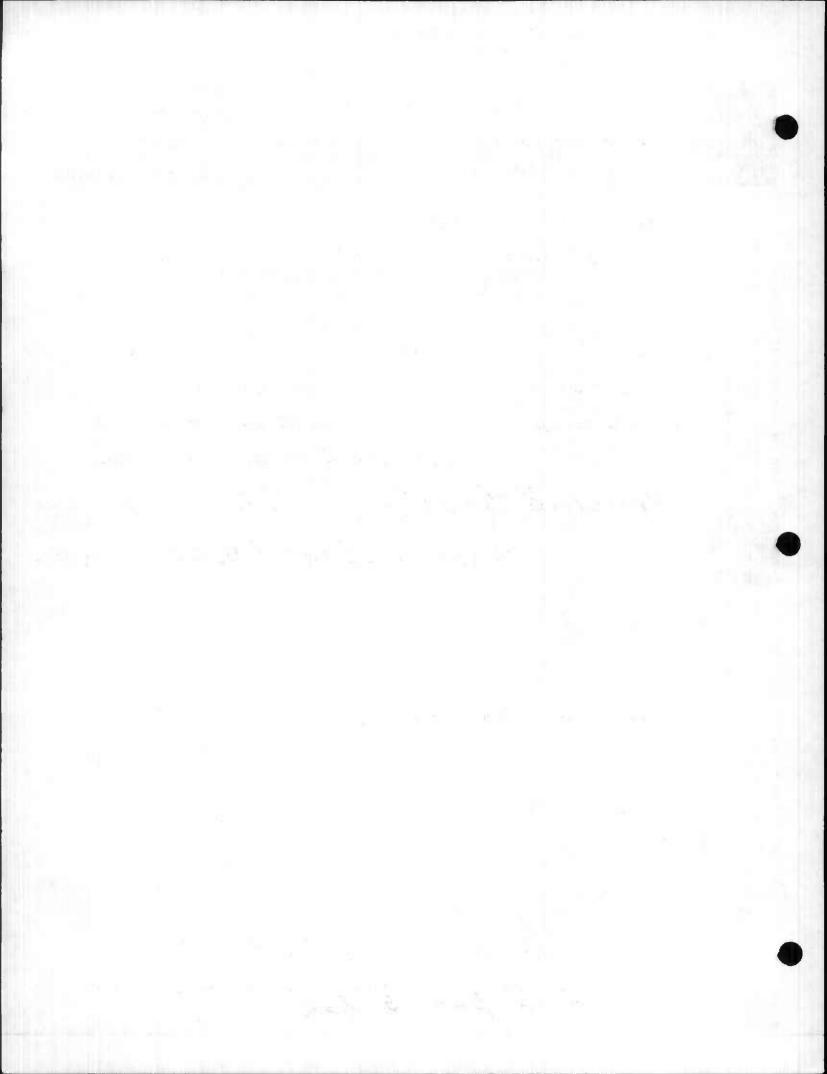
William S. Bremer M.D. 800 S. Talbot St. St. Michaels, Maryland 21663

31. Dete tiled (Month, 1908) 2 1 1999 32. Registration S. Sparks

State Registrar 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



State of Maryland / Department of Health and Mental Hygiene  $9\,9$ 

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Deeth Day 1999 Month **Physician** June 17, 3:15 .m. Charles Taylor Pridgeon /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Heron Point Chestertown 8. Data of Birth (Month, Day, Year) April 3, 1 If Under 24 Hrs. Hours Min. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) If Under 1 Year 6. Sax Birthplaca (Stata or Foreign Country) **Funeral** 11XM 2□ F Months Days 88 212-38-7010 1911 Baltimore, Maryland Director Usual Rasidance of Decedant death with the Maryland 10d. Inside City Limits 10c. City, Town or Location pemit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic avent, the Manical Examiner must be northled at 10a Stata 10b County Yas 2 No Directo Kent Maryland Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 403 Heron Point 21620 USA Funerai Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, 11. Marital Status 12. Was Dacedant Evar in U.S. Black, White, etc. Armed Forcas' 1 Never Married 2 Married YOYes 2 No Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Collaga (1-4or 5+) Elemantary/Secondary (0-12) Dentist Dental Hygiene 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Albert Johnson Pridgeon Annie Rooney 19b. Mailing Addrass (Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Pnint) Dr. Charles Pridgeon/Son 203 Coventry St., Marietta, Ohio 45750-2628 20b. Place of Disposition (Nama of cematary, cramatory or other plece) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 XCrametion 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Center, LLC 6/18/99 Stevensville, MD 22. Nama and Addrass of Facility 21. Signature of Funeral Sarvice Licania Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 of enter the mode of dying, such as cardiac or respiratory arrest, 23a. Pert1. Enter tha diseasa, or confplication. That caused the daeth. Do not e shock, or heart fellura. List only ona care on each line. Approximata Interval Batw Interval Batween Onset and Death **Physician** /Medical Immediata Causa (Final converse extent secious T disaasa or condition rasulting In death) Examiner Dua to (or as a consequence of): Examiner physician and s the bunel-trensit Sequentially list conditions, if any, laading to Immadiata cause. Entar Underlying Couse (Disease or Injury that initiated avents rasulting in daath) Last Dua to (or as a consaquanca of): P.O. Box 68760. Physician/Medical Dua to (or as a consaquance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? isigned by the 1 Yes 2 No 3 Probably 4 Unknown p 24b. Wera autopsy findings available prior to completion of causa of death? 24a. Wes an autopsy Completed peen certificate has 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

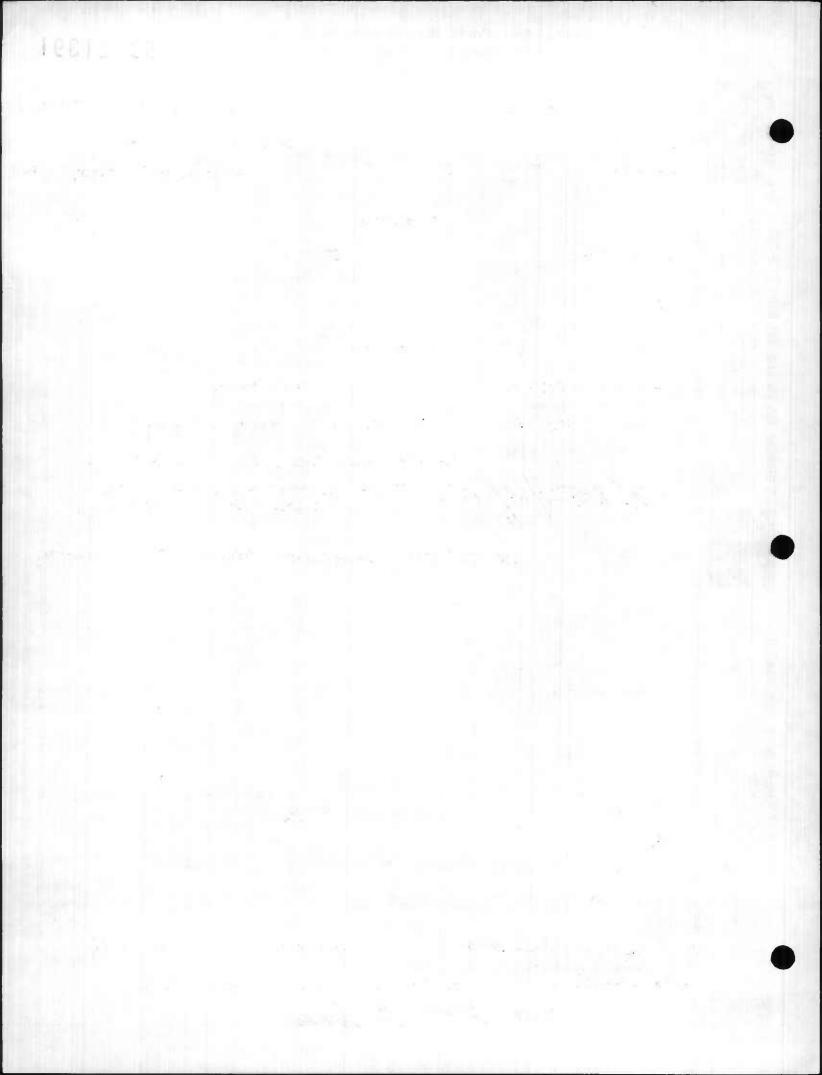
To the Funeral Director: After this certifice Be 25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 0 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Mennar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of Certification: 1 Natural 2 Accident 5 Panding Injury 1 Yas Invastigation 3 Sulcida 6 Could not be dataminad 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) end mennar as stated.
2 Madical Examiner: On the basis of exemination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifian Medical 29b. Signatura and titla of cartifiar 29c. Licansa numbar 29d. Data signed (Month, Day, Year) my 17-138-24 15 30. Name and address of person who complated causa of death (Itam 23a) (Type, Print) 122 Speer Road, Suite 5, Chestertown, Maryland 21620 John Seymour 31. Data filad (Month, Day, Yeer) 32. Registrar's Signatura State

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JUN 18

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month Yaar 26, 1999 Rosalie Maude 2:10 AM Powers June 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, giva street and number) 4c. County of Death St. Mary's Nursing Center Leonardtown Mary's If Undar 1 Yaar If Undar 24 Hrs. 6. Sex 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) 8. Data of Birth (Month, Day, Year) Days 1 M 2 K Yrs 89 June 7, 1910 Maine Usual Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No St. Mary's Leonardtown 10f. Zip Coda 10g. Citizen of What Country? 22680 Cedar Lane Court, Apt. 1326 20650 U.S.A. 12. Was Decedant Ever in U.S. Armed Forces? 1 ☐ Yas 2 ☑No If Yas, Giva Yaer or Datas: 13. Was Dacedant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 1 ☐ Navar Marriad 2 ☐ Married 1 ☐ Yas 2 🗓 No Specify: Specify. White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elemantery/Secondary (0-12) College (1-4or 5+) Secretary U.S. Government 17. Fether's Neme (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Harlan Keves Maude Ordway 19a. Informant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Howard Stoodley/Son-in-Law 304 Bishops Ct., Falls Church, VA 22046 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - City or Town, Stata National Memorial Cemetery

6/30/99 1 N Burial 2 □ Cramation 3 □ Ramoval from Stata Falls Church, VA 4 □ Donation 5 □ Othar (Specify) 21. Signature of Funeral Service Licent 22. Nama and Addrass of Facility Mattingley-Gardiner Funeral Home, P.A. ications that caused the death P.O.Box 270, Leonardtown, MD 20650 alven Part1. Entar the disease, or complication shock, or heert feilure. Vist only one of that antar the mode of dying, such as cardiac or respiratory arrest, Approximata Intervel Between Onset and Death Due to (or as a consequence of): Dua to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings availabla prior to completion of cause of daath? 24e. Wes en autopsy performed? 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical examiner? 26. Piece of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 28c. Injury et Work? 28e. Dete of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Time of 5 Panding 1 ☐ Yas 2 ☐ No Invastigation 6 Could not be datarmined 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)

Examiner The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, or Attanding Physician:

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Examiner Physician/Medical by Completed Be Certification: To

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altimore, Maryland 21215-0020

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11. Marital Status

10e. Street and Number

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27. Mennar of Daath

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2 Accidant

3 ☐ Suicida

4 Homicide

12 Certifying Physician: To tha best of my knowladga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. Licansa number 29d. Data signed (Month, Day, Year) D33470 June 28, 1999

30. Nema end eddress of person who complete of deeth (Item 23e) (Type, Print) Bhasker Jhaveri, MD

Hollywood, Maryland 20636

Registrar

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31. Dete filed (Month, Day, Year)
JUN 2 9 1999

32. Registrar's Signatura





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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dev **Physician** Kobbins rederick 1999 /Medical June 11 10:15 am 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 2501 Millington Road (Residence) Millington Kent If Under 1 Yeer If Under 24 Mrs. 8. Dete of Birth (Month, Dey). 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Deys t∕□ M 2□ F 214-34-5875 62 Director May 9, 1937 Cambridge, MD Usual Residence of Decedent Pages 1 end 2 should be filled within 72 hours efter deeth with the Meryland nent of Heelth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23s or 28s-f ahow 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 25s-f show other treumstic event, the Moores Examinar must be notified at 1 ☐ Yes 3(TNo Director Maryland Queen Annes Millington 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2501 Millington Road 21651 U.S.A. Funeral 12. Wes Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 14. Rece - American Indien, Black. White, etc. 1 Never Married 200 Married 1XXes 2 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No þ If Yes, Give Yeer or Dates: USAF Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Truck Driver 12 Trucking 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Frederick Robbins Ida Koski 2 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Linda L. Robbins/Wife 2501 Millington Road, Millington, Maryland 21651 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete Depertment of Important: If it any Injury or conce. XXBuriel 2 Cremetion 3 Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Dorchester Memorial Park 6/19/99 Cambridge, Maryland 21. Signeture of Juneral Service Licenses 22. Name end Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. PO Box 270, Millington, Maryland 21651-0270 ellows ar 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset end Deeth **Physician** umur-Astrocytoma /Medical Immediate Cause (Final diseese or condition resulting In deeth) UYE Examiner Due to (or es a consequence ot): Examiner physicien and the bunai-trensit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence ot): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence ot) signed by the ettending I be detached for use es Pert II. Other significant conditione contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Wes en eutopsy performed? 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed hes 1 Yes 2 1 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

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2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) end menner stated. 29e. Certifier Medical 29d. Date signed (Month, Dey, Year) 29b. Signature and title of centifier 29c. License number milling ton Rd 30. Mane end eduress of person who completed cause of deeth (Item 23e) (Type, Print) K. Sipala CENP, MSN Bizabeth Frederick Delboy,

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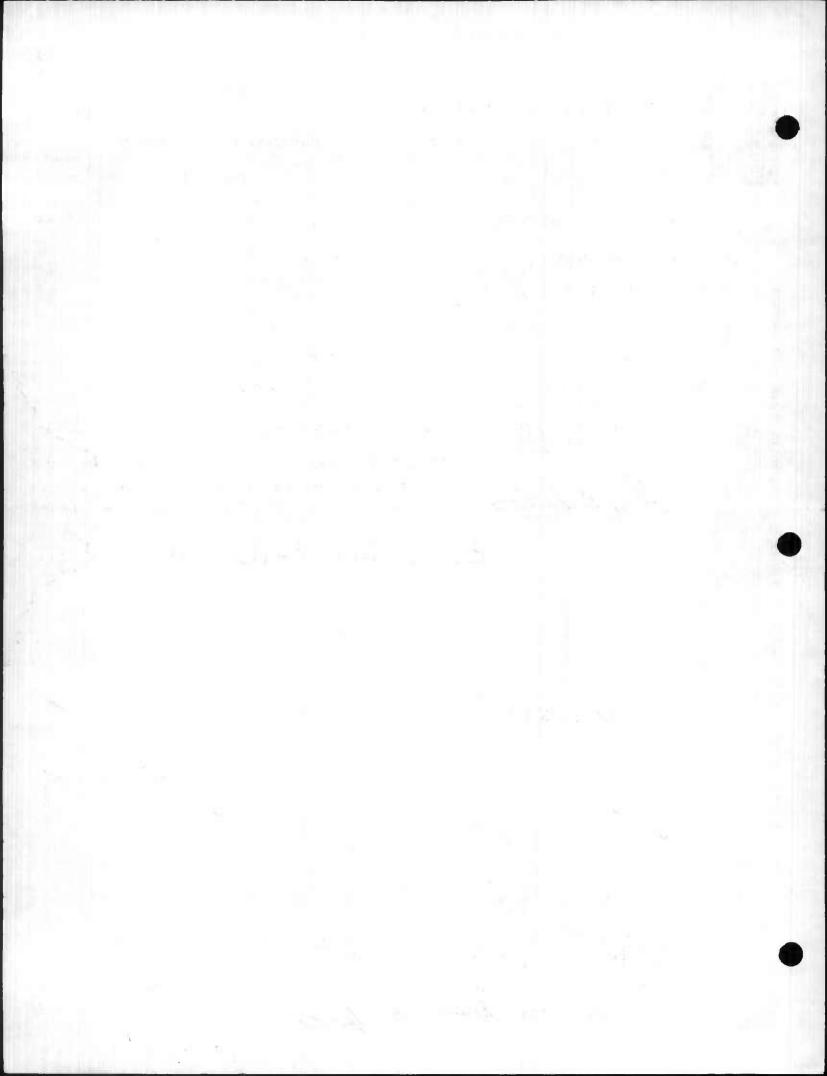
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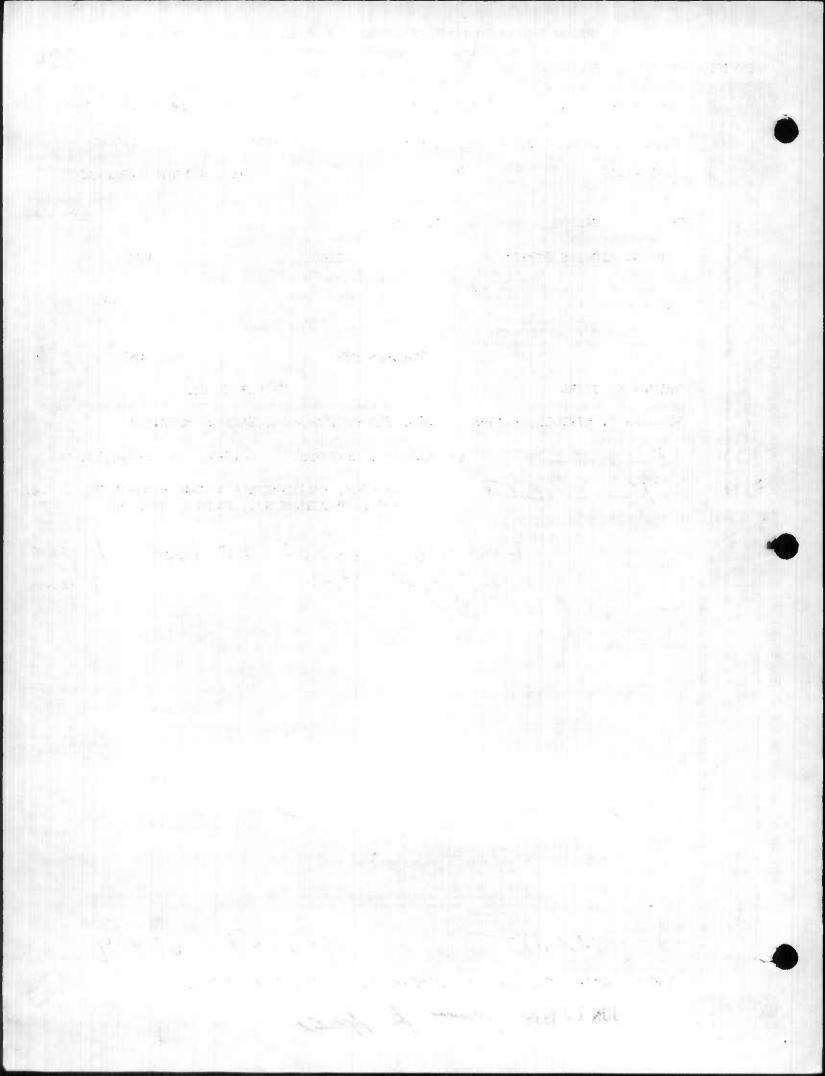
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	RUSSELI	SCHILLI	NG, M.D.		LIBERTY	ST., CEN	TREVILL	E, MD 216	17		

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Day **Physician** Joyce M. V. K.

4a Facility Name (If not institution, give street end number) Kobinson 19, 1999 4c. County of Deeth 1350 June /Medical 4b. City, Town, or Location of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country)
Washington D.C. 7. Age (In yrs. last birthday) 5. Sociel Security Number **Funeral** 578-84-1505 1 □ M 2 X F Yrs. 07-10-5 Director Usuel Residence of Decedent 2 should be filed within 72 hours efter death with the Maryland and Mental Hygiene. 10a. Stete 10c. Gity, Town or Location 10d. Inside City Limits 1 KYes 2 □ No MD Rincess Director JOMERSE 1 10e. Street end Number Of Zin Code 10g. Citizen of What Country? 7 is marked other than "naturel", or items 23s or troumstic event, the Medical Examiner must be a 21853 13525 bruodstr Funerai 12. Was Decedent Ever In U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Bleck, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Detes: 1 Never Married 2 Merried 1 Yes 2 No Black Specify: by 3 Widowed 4 Divorced M. Robinson Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 18e Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Gollege (1-4or 5+) Elementery/Secondery (0-12) ER: CAI ADORER 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Be Kobinson ARAH 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Pages 1 and 2 Kobinson Mother 5303 N.E. Mashington 20019 Health 27 DARAL 5303 Jay N.8 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 70 important: If it any injury or c 1 Burla1 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) ncoln Memorial Campby 6-2599 Bladens burg. P2. Name end Address of Fecility 21. Signature of Funerel Service Licenses 30639 Hampden Ave. Pincess Anne, Do not enter the mode of dying, such as cerdiac or respiratory errest, 21853 MD 23a. Pert 1. Enter the disease, or complications that ceused the death. shock, or heart failure. Limit one ceuse on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medicai Examiner Physician/Medical Examiner and I-trensit thet the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of) physician ar s the buriel-tr P.O. Box 68760. Due to (or es a consequence of): 98 980 ed by the e 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 1 Yes 2 No 3 Probably 4 Unknown ó Division of Vital Records, The law requires 24b. Were autopsy findings eveilable prior to 24e. Wes en eutopsy performed? Completed completion of cause of deeth? is certificete has director, page 2 211 No 2 No 1 Yes 1 Yes or Attending Physician: 25. Was cese referred to medicel examiner? Be 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funerai 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? After 1 PNeturel 5 Pendina 1 Yes 2 No death. Investigation ector: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) a Funeral Direction of Filled in bietely filled in b 4 Homicide efter 1 🗹 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) end manner as stated. 29e. Certifier edical 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date and piece, and due to the ceuse(s) end menner steted. (Check only one) To the Vithin 2 29b. Signature and this of certifier 29c. License number 29d. Date signed (Month, Dey, Year) A. DAVIS mis 30. Nems and address of person who completed cause of death (Item 23e) (Type, Print) 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture

State Registrar

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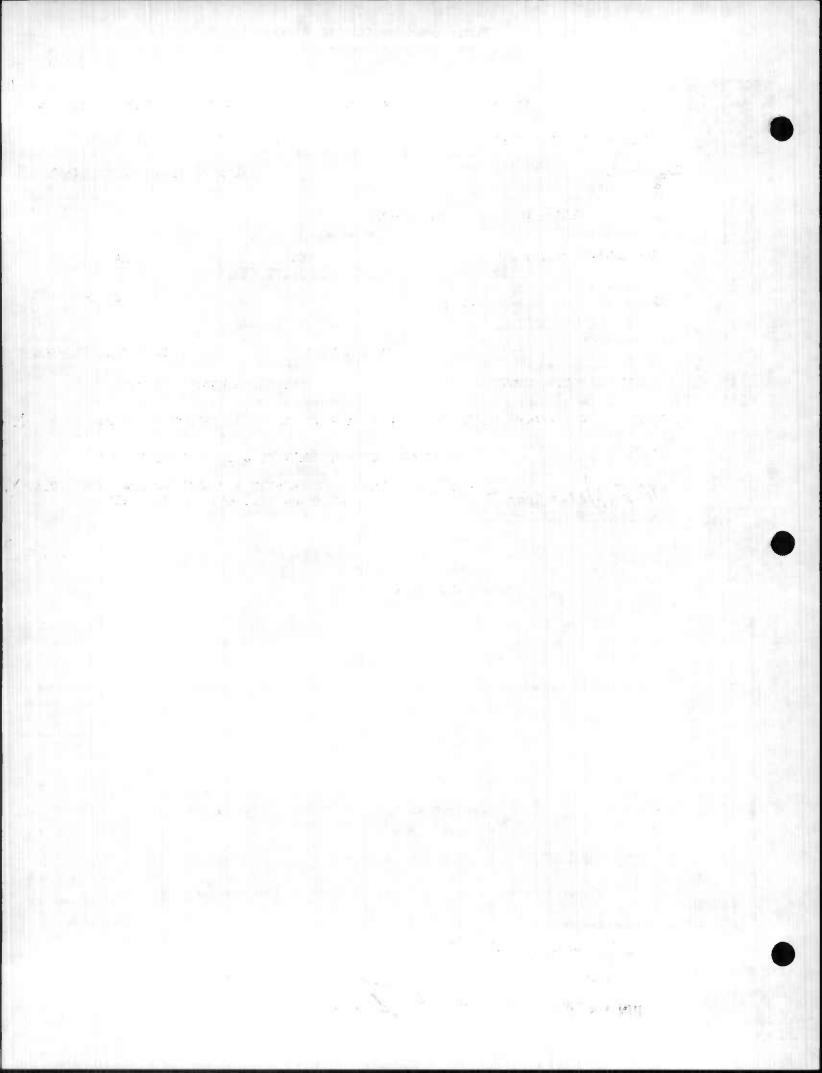
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State of Maryland / Department of Health and Mental Hygienes o

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age ento Ht: H		20a. Method of Disposition  1 XBuriel 2 Cremetion 3 F 4 Donetion 5 Other (Specify)	temoval from State		netory or other ple	ce) CEMETERY		20c. Location - (		wn, State
permit. P Departm Importar any injur		21. Signatura of Funaral Servica Licens	W C.	SP FE	LLOWS, H	ELFENBEIN	& NEWNA	M FUNER	AL H	OME, P.A
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To the Hospital or Attanding Physician: The law requires that the death cert within 24 hours after deeth.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	edical (	29e. Certifiar (Check only one) 1 Certifying Physical Check only cone)	sician: To the best of my ner: On the basis of examend menner steted.	knowledge, deeth ninetion end/or In	n occurred et the ti vestigetion, in my	me, dete end place opinion, deeth occu	, end due to tha carred et the tima, de	ause(s) and mar ata end placa, e	nner es st and dua fo	eted. fhe cause(s)
Vithin To the	N N	29b. Signature and title of cartifiar			29c. Lican	sa number	2	9d. Data signed	(Month, I	Day, Year)
- > - 0		1 Robran	_ M. D	6	D2	-9168		6/18/	29	
		30. Name and address of person who co		(Item 23e) (Type,	Print)					
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State of Maryland / Department of Health and Mental Hygiene o

						Ce	rtificate	of	Death		F	leg. No.	6	139	1
			1. Decedent's Neme (First, Middla, Last)  2. Data of Death									th	V	3. Time of	Death
	Physici /Medic		SARAH AVA LEE SPENCE								Month 06	Day 12	99	5:20	p.m.
Exam			4a. Facility Name (If not institution, giva street and number)				4b. City, Town, or Lo				cation of Death	4c. County	of Death		
			Caroline Nursing Home, Inc. Denton, Maryland Caroline												
	Funeral Director		5. Social Security Number 425-42-0059 Usual Residence of Decedent	4 D 44 X-X-	Aga (In yrs. Ia 74	Yrs.	Months I	Yaar Days	If Under 2 Hours	Min.	8. Data of Birth (Month, Day NOV . 19,	1924	9. Birthpi Coun MISSI	laca (Stata or (ry) SSIPP]	Foreign
	dend Mend		10a. State 10b. County		10c. City,	Town or L	ocation						1	0d. Inside Cit	y Limits
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	72 hours after death with the Maryland nature!', or heme 23a or 28a-f show olds Evanther must be noutled at	ie	10e. Street and Number				10f. Zlp C	ode			1	Og. Citizen of	What Coun	try?	
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20		by Funeral Director	11. Marital Status  1 Navar Married 2 Married  1 Navar Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever In U. Armed Forces?  1 Yes 2 Moored  1 Yes, Give 1 Yes, Give 1 Yes, Top Dates:			<ul> <li>13. Was Decedant of Hispanic Origin? (Specify Y if Yes, specify Cuban, Mexican, Puerto Rican</li> <li>1 ☐ Yes 2 X No Specify:</li> </ul>					ecify Yes or No- Rican, atc.)	r No- 14. Race - American Indian, Black, White, etc.  Specify: WHITE			
21215-0020	hour turns	b p		16a Door	6a. Decedent's Usual Occupation					16b. Kind of Busin			and the desired		
15	in 72	lete	15. Decedent's Education (Specify only highast grada completed)				(Giva kind of work dona during most of workii lifa. DO NOT usa retired)				ng	100. Killa of B	siness/industry		
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D	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hyglene. Important: if item 27 is marked other than "naturet, or items 23a or 28a-f show surportant: or other traumatic event, the Medical Evantment must be not each and an once.		17. Fathar's Nama (First, Middla,	Last)							e (First, Middla, Maiden Surnama)				
lar			OSCAR G. COURTNEY			ALICE					PARKER				
Maryland			19a. Informant's Name/Relations	19b. Melli	ing Address (S	Street	and Numbe	r or Rura	I Routa Numbe	I Routa Number, City or Town, Stata, Zip Code)					
			JULIUS A. SPEN	CE/ HUSBAND	)	1103	6 CORD	OVA	ROAD	, CO	RDOVA,	MD 2162	.5		
ore						ce of Disposition (Nama of natary, crematory or other place)				Date	20c. Location	Oc. Location - City or Town, State			
E			INTRUME 2 LIGHDATION 3 LINEMOVALITOM STATE I								-16-99	EASTON, MD			
Baltimore,			21. Signature of Funeral Saprice	F	22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME										
-	0		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.  Approximate interval Between												
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Ē	ng P	on:	27. Manner of Death Naturel 5 ☐ Pendir	28a. Date of I (Month,	Day Year)	28b. Time o Injury		. Injur Wor			28d. Describe h	ow Injury occur	red		
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	the Hosp hin 24 hos the Fune upletely fi	Medical	29e. Certifier  (Check only one)  10 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.												
	5 ¥ 5 0		29b. Signature and titla of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)												
			30. Nama end address of person who completed cause of death (Item 23a) (Type, Print)  Janes Siles 920 Market St Deutov 482163)												
	-0:	40	31. Date filed (Month, Day, Year)	32 800	istrar's Signatu	179	arne	0	5	, (	Le	N (O)	V	412	
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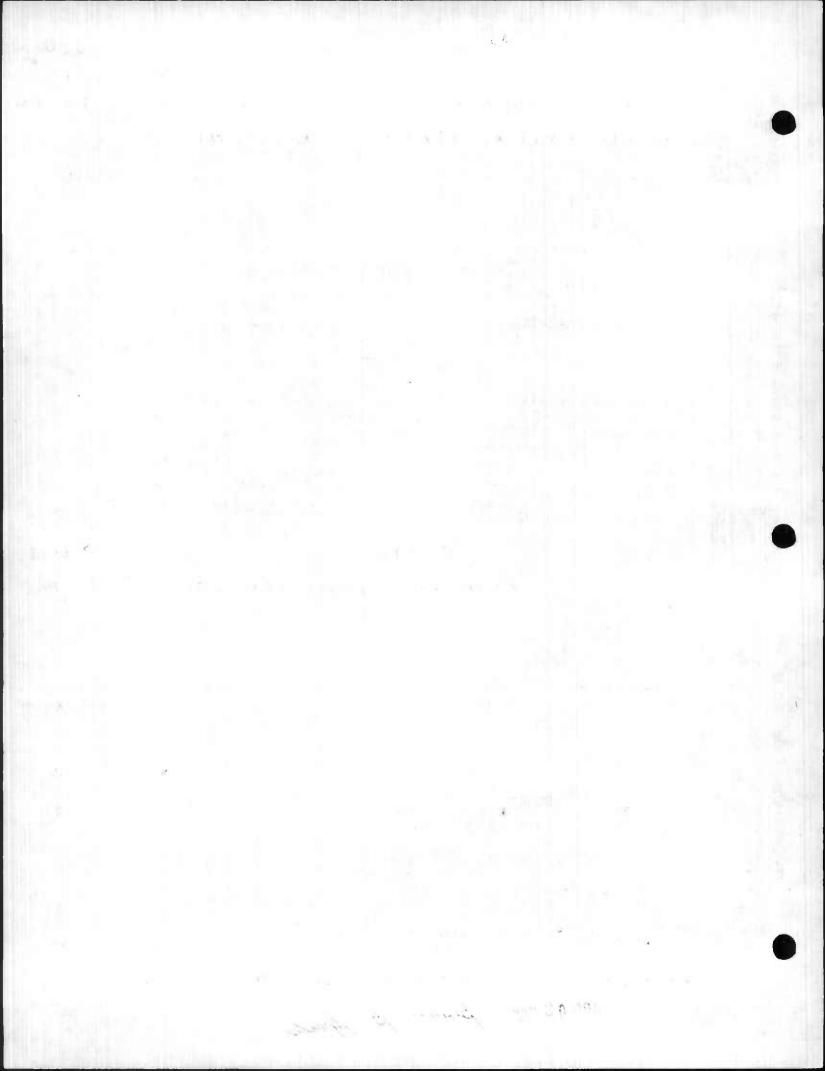
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State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** UDO SCHUWALDW 9.05 P.M. MARCH 1999 30 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CENTER BALTIMORE Baltimore HOSPITAL HARBOR If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Yeer Months Deys 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 € M 2 F 43 Yrs. Director 217-02-3382 04/24/55 Germany Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Wedical Examiner must be notified at 1 ☐ Yes 2 🔀 No MD Director Dorchester Hurlock 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4965 Harrison Ferry Road 21643 United States Funeral 14. Race - American Indien, Bleck, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S Armed Forces? hours efter 1 Yes 2 No If Yes, Give Year or Detes: 1 Never Married 2 Merried Baltlmore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7: Hygiene. other then "na Elementary/Secondary (0-12) College (1-4or 5+) Electrical Electrician 4 18. Mother's Neme (First, Middle, Meiden Sumame) permit. Pages 1 and 2 should be flit Department of Health and Mentel Hy Important: If Nem 27 is marked oth any liny or other treumatic event Rotes. 17. Father's Name (First, Middle, Last) Be Waltraad Görnert George Schuwalow 2 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4965 Harrison Ferry Rd., Hurlock, MD 21643 Penelope Schuwalow/Spouse 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 ☐ Burial 2 Cremetion 3 ☐ Removel from Stete Cambridge Crematory 4/3 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, MD 21. Signature of Funeral Service Licenses 22. Neme end Address of Facility Framptom-Hawkins-Eskow Funeral Home, PA hail PO Box 43, Federalsburg, MD 21632

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Exem Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediete Causa (Final SEPSIS DAYS disease or condition resulting in death) Examiner 1 YEAR METASTATEC RENAL the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Due to (or es e consequence of) Records, P.O. Box 68760. attending physicien Physician/Medical Due to (or as a consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 WUnknown be det P 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed 1 Yes 2 No 1 Yes 2 No Division of Vital Hospital or Attanding Physician:
 24 hours after deeth.
 Funeral Director: After this cartifical letely filled in by the funeral director, Be 25. Wes case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Certification: 1 Netural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide edicai 29a. Certifier 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner as stated. (Check only one) 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner steted. To the To the Comple 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESIDENT Mitter Nahar P 10056 MARCH , 30, 1999 HOUSE STAFF 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

ANITA NAHAR, 3001 SOUTH HANOVER STREET BALTEMORE MD 21225 31. Date filed (Month, Day, Year) APR 02 32. Registrer's Signeture 1999



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99

Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 1999 Month **Physician** June 15, Martha Louise Stevens 4:45 p.m. /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Corsica Hills Nursing Home Centreville Queen Anne's If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Months, Day, Year)

Min. October 25, 1 5. Social Security Number Birthplace (Stete or Foreign Country) 7. Age (In vrs. lest birthday) **Funeral** 1 M 3 X 83 218-20-8662 Yrs. 1915 Barclay, Maryland Director Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If few 27 is marked other than "natural", or Nems 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be above. 10a Stete 10h Counts 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Queen Anne's Centreville 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 215 Armstrong Street 21617 USA Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, 11. Marital Stelus Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Merried 1 Yes 2 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) School Teacher Education 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) James Clayland Stevens Helen Roe 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Peggy Stevens/Niece 711 Roundtop Road, Chestertown, Maryland 21620 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Church Hill Cemetery 6/17/99 Church Hill, Maryland 22. Neme end Address of Facility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620, Approximate and the mode of dvino. such as cardiec or respiratory errest, Interval Between Onset and Deeth **Physician** END STRGE PARKINSONS /Medical Immediate Cause (Final disease or condition resulting In deeth) Examiner Due to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initioted events resulting in deeth) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai Due to (or as e consequence of): 88 Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 Yes 25 No 3 Probably 4 Unknown DEMENTIA à 24b. Were eutopsy findings available prior to completion of ceuse of death? 24e. Wes an autopsy Completed certificate has b 2 No 1□Yes No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, i 25. Wes case referred to medicel examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 ☐ Yes 211 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Meaner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Naturel 5 Pending investigation 1 Tes 2 No 2 Accident 3 Sulcide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier (Check only one) McCertifying Physician: To the best of my knowledge, death occurred et the time, dete and piece, end due to the ceuse(s) end menner as stated.

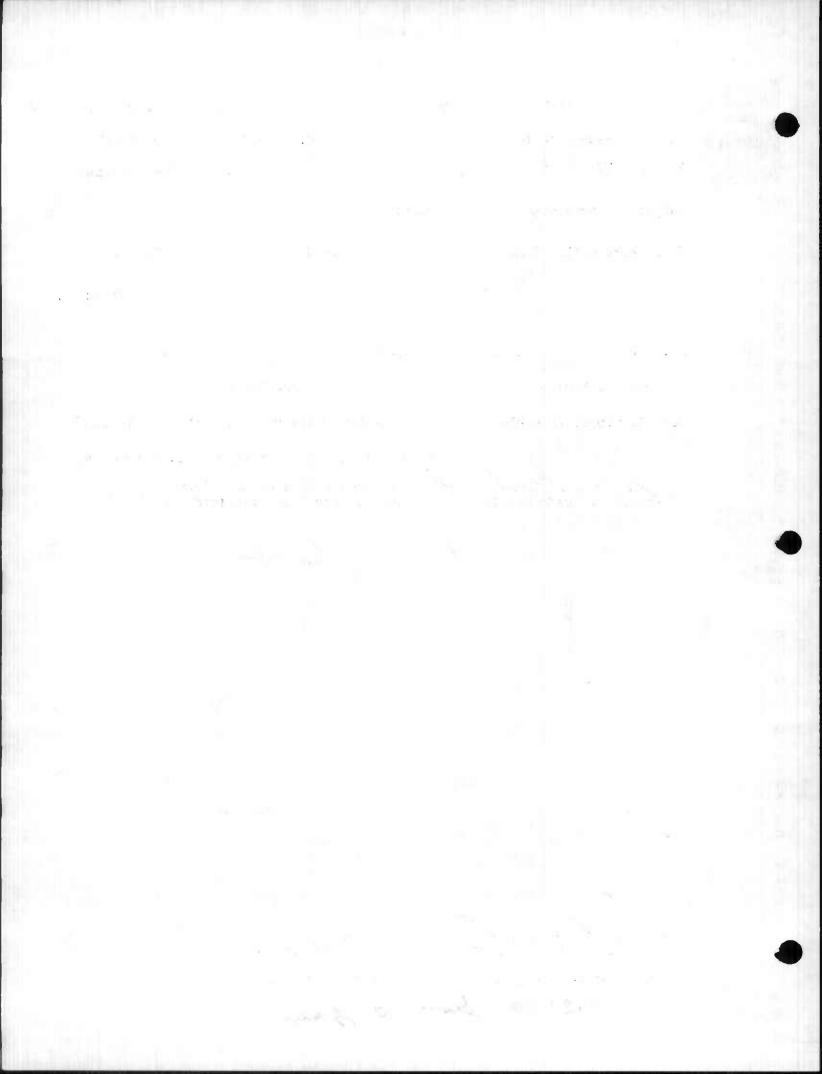
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the cause(s) Medical 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture and title of certifier 99 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Helen A. Noble, 122 Speer Road, Suite 5, Chestertown, Maryland 21620 31. Date filed (Month, Dey, Year)
JUN 17 1999 32. Registrer's Signeture State

**DHMH 16 Rev 6/95** 

Registrar

## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 2 1 4 0 0

			Decedent's Name (First, Middle, Last)	UI DeallI	-	th	3. Time of Death				
	Physici /Medi		ROBERT F. SOMERS		Month Dev						
	Exami		4a. Facility Name (ff not institution, give street and number)	4b. City, Town, or I							
			4212 Jacksonville Road				erset				
	Funeral Director		5. Social Security Number 213-12-5077 6. Sex 12 F 80 Yrs. last birthday) 1 Months World Residence of Decedent	Year if Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Dey, August 13	, 1918 M	Birthplaca (Stete or Foreign Country) [aryland				
	e Maryland Sa-f ahow	ctor	10a. State 10b. County 10c. City, Town or Location Crisfield				10d. Insida City Limits 1 ☐ Yes 2 No				
	th with th	Funeral Director	10e. Street and Number 10f. Zip C 4212 Jacksonville Road	June   16, 1999   10:40 A.1     June   16, 1999   10:40 A.1							
020	be filed within 72 hours after death with the Maryland nat Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status  1 □ Never Married  3 □ Widowed 4 ♣ Divorced  12. Was Decedent Ever in U,S.  Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:  13. Was Decedent Ever in U,S.  Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		pecify Yas or No- Rican, etc.)	Black,	White, atc.				
21215-0020	within 72 he ene. than "natur	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Occupation done during most of work retired)	king	16b. Kind of Busin	ness/Industry				
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Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumetic evonce.		Bradsha			me					
			Robert H. Bradshaw, Jr	Main St C	risfield	, MD 21					
)	Physician /Medical Examiner	er	immediate Cause (Final disease or condition resulting in death)  e. Matestatic  Due to (or as e consequence of):	/			a month				
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Divisi	al or Attending s after death. I Director: After ad in by the fune	Certification:	3 Suicida 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)	office							
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	To the within To the comp	Me		lcense number 3 6 3 7 8							
			30. Name and address of person who completed cause of ceath (Item 23e) (Type, Print) David E. Cowall, M.D 145 E. Carroll St								
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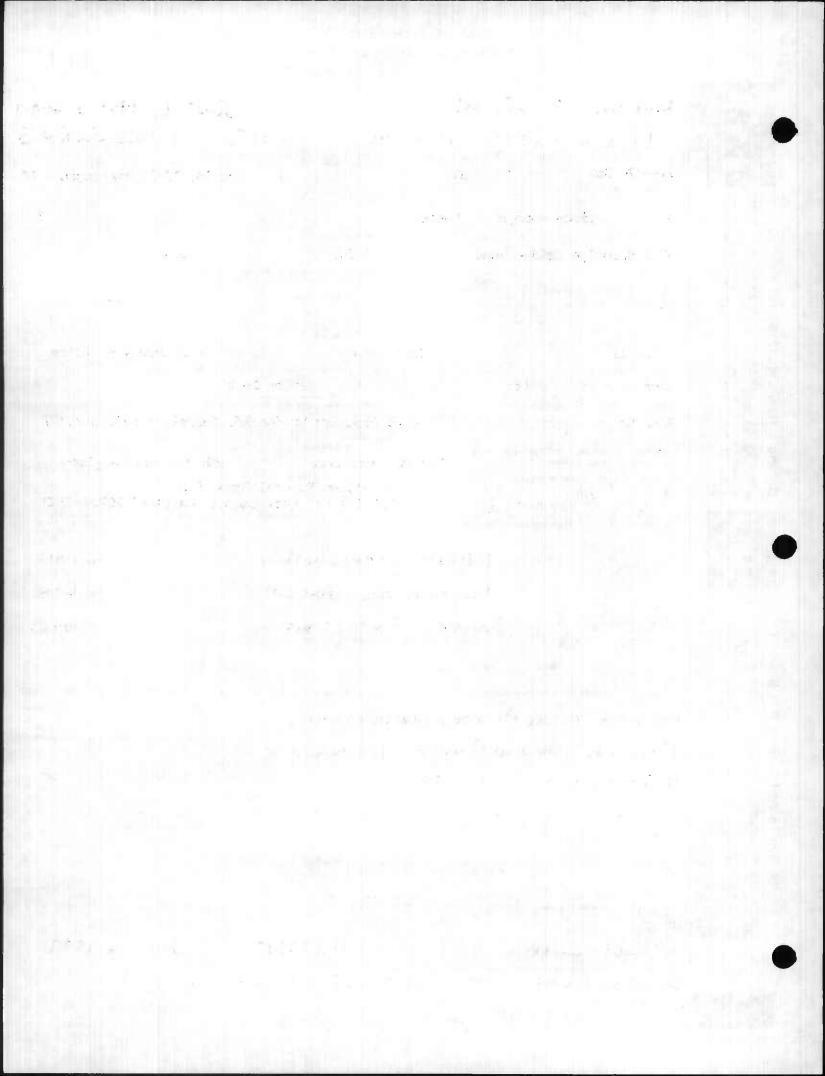


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State of Maryland / Department of Health and Mental Hygiene 0

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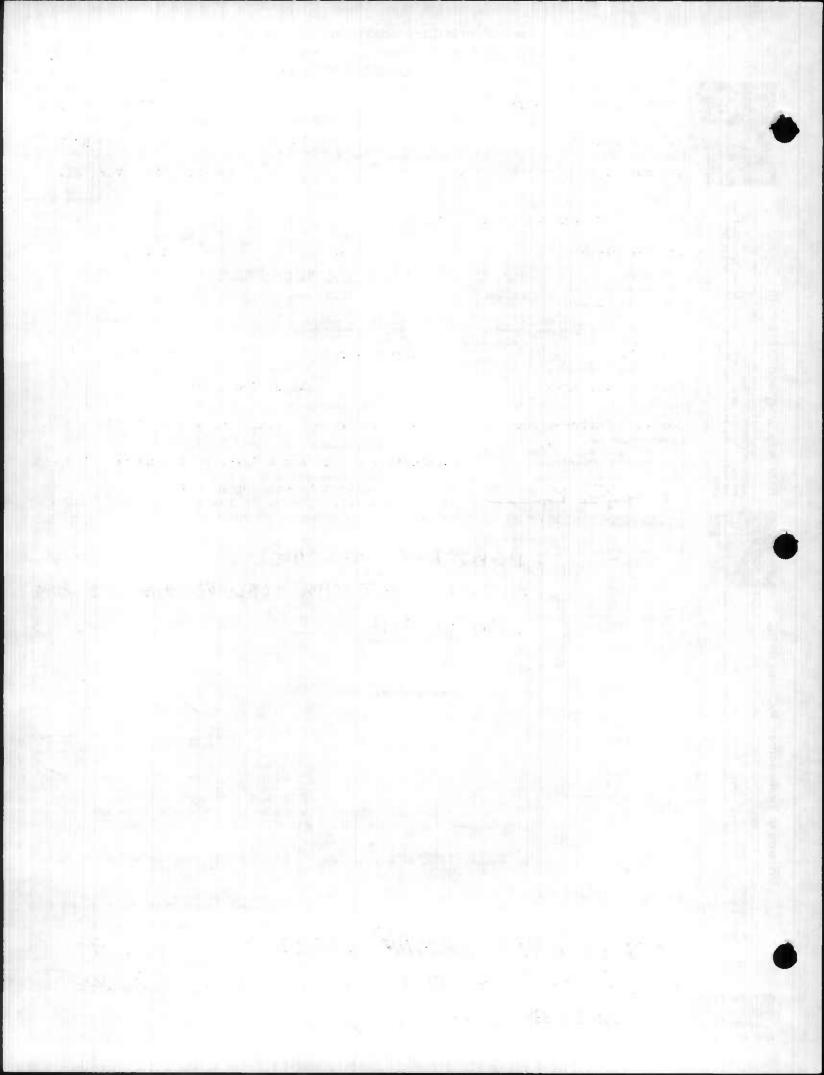


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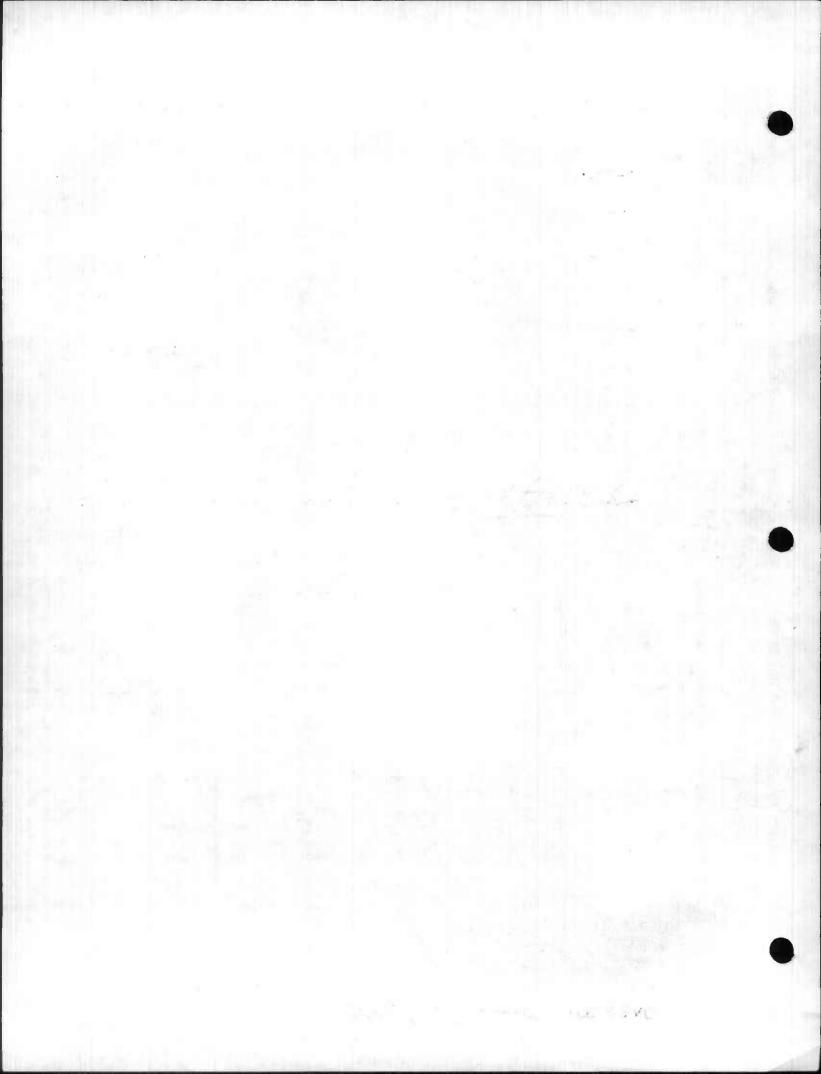
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	_	30. Name and address of person who	ade 9811	Malla	(VD)	pr	ive	Lav	rel s	nd2	07	4		
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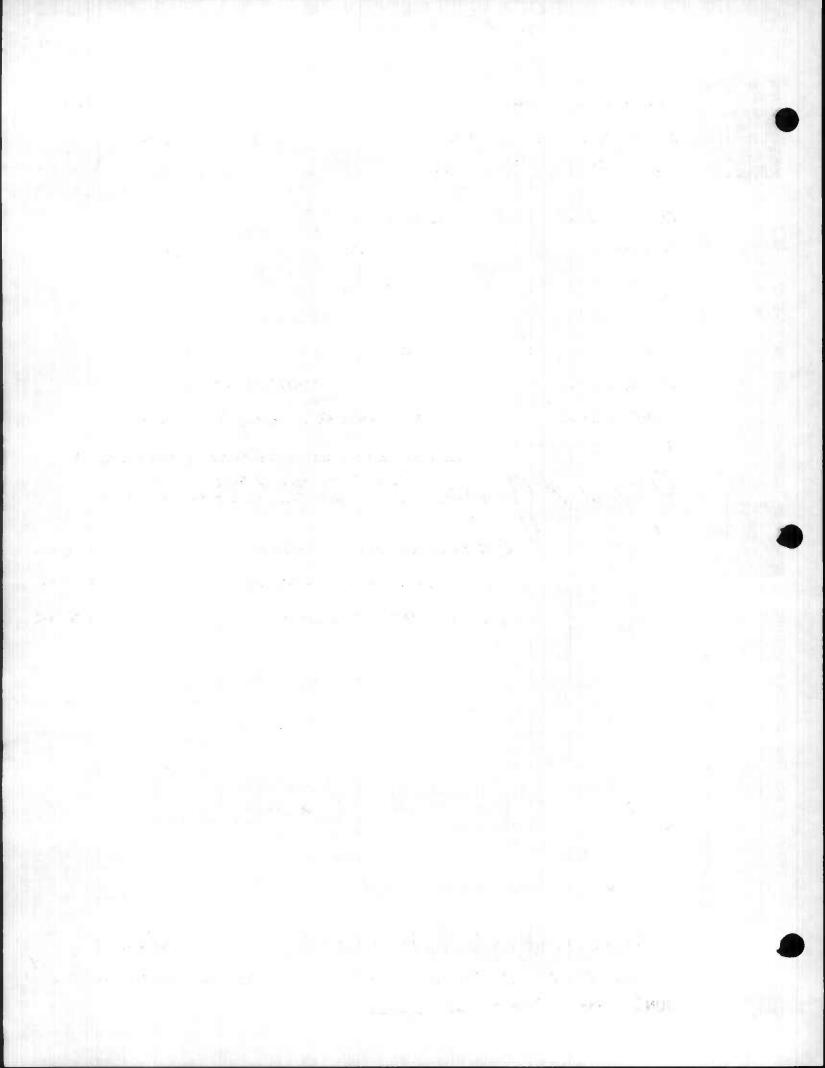
Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #23 PART I, PER MD G776 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Dey Month Year **Physician** EVELYN June 26, HICKMAN STELLERN 1999 11;30 pm /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1203 Old Telegraph rd. Warwick Cecil If Under 1 Year | If Under 24 Hrs. 5. Societ Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) **Funeral** 1□ M 2 F Deys Min Months Hours 92 Yrs. Director 219-05-7758 3-24-1907 Maryland Usual Residence of Dece the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. toside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Maryland Cecil 1 ☐ Yes 2 No Warwick Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1203 Old Telegraph Rd. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or here 23a any Injury or other traumatic event, the Headest Essentian 2008. 21912 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Nott Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. 11. Maritel Status Black, White, etc. 1 Never Married 2 Merried Specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Domestic 12 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Ernest Hickman Eva Handy 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Jack E. Hickman 5121 Pontiac Rd., Drexel Hill, Pa. 19026 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 1 Burlat 2 □ Cremetion 3 □ Removel from State Sunny Ridge Cemetery 6-29-99 Crisfield, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic DANIELS & HUTCHISON FUNERAL HOME Broad St., Middletown, N. DE.19709 23a. Part1. Enter the disease, or complications that caused the yeath. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner physician and s the burisi-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): DEBILITATION Box 68760. Physician/Medical 50 080 for 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 50 signed by i 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, P been signature 24b. Were autopsy tindings available prior to completion of cause ot death? Completed 24a. Was an eutopsy performed? page 2 s has 2 No 1 Yes 1 Tes 2 No 25. Was case referred to medicat examinar? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 this funeral 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Division Attending death. 1 Yes 2 No 2 Accident or Attandation of the or Attandation of the or Attandation of the order of the orde 6 Could not be determined 3 Suicide 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, tarm, street, fectory, office building, etc. (Specify) filled in by 4 - Homicide Hospital 24 hours a Funeral D 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) end menner es stated. edicai To the Hosp within 24 hos To the Fune completely fi 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end plece, and due to the ceuse(s) and manner stated. (Check only one) 29b. Signature and ittin of 29c. License number 29d. Date signed (Month, Day, Year) C 100 2306 8 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) 19702 Newark, De. Dr. John Goodill, 2600 Summit Bridge Rd. Glasgow Med. MD Centr, 31. Date tiled (Month, Dey, 32. Registrar's Signature State JUN 2 8 1999 Registrar



# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Certifica	ate of	Death		Reg. No.				
		1. Decedent's Name (First, Middle,	Last)					2. Date of Dea	ath		3. Tin	ne of Death	
		Leokadija S.	Smith					June	27	1999	5:	20 AM	
		4a. Facility Name (If not institution,	nive street end number)				4b. City, Town, o	r Location of Deeth		nty of Death			
		Calvert Manor H	lealthcare	Contor			Risina :	Sun	Cec	il			
Funera			Sex 7. Ag	e (In yrs. lest birt	hday) If Un Monti	der 1 Year	If Under 24 Hr	s. 8. Date of Birt	h	T	lace (St	ete or Foreign	
	L	155-56-2675 Usual Residence of Decedent	1□M 2Ž F	88	Yrs.	no boys	TIOUIS IVII	Oct. 7,	1910	Penr	isyl	vania	
show d at	-	10a. State 10b. County		10c. City, Town	or Location			~~		10		de City Limits	
he M	the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours effect death.  The Functs effect death.  The Functs effect death.  The Functs effect death.  The Functs effect death.  The Functs effect death.  The Functs effect death.  The Functs effect death.  The Functs effect death.  The Functs effect death.  The Function of the cities and 2 should be difficult on the maryland.  The Function of the cities as the function of the cities of the cit	MD Cecil	2	Risir	ig Sun					Yes 20 No			
F 9 K	늅	10e. Street and Number				Zip Code				of What Coun	try?		
ath v	rai	21 Surrey Lane				1911			USA				
21215-0020  within 72 hours after de giene. Truban *netural; or frem tra Medical Examiner.	by Fun	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1  Yes 2 1		If Yes, s	pecify Cub	Hispanic Origin? ( lan, Mexican, Pue Specify:	(Specify Yes or No- irto Rican, etc.)					
2 ho	ted	15. Decedent's	Education	16a.	Decedent's U	sual Occu	pation		16b. Kind of	Business/Inc		e	
hin 7	ple	(Specify only highest g Eiementary/Secondary (0-12)	rade completed)  College (1-4or !	(A)	(Give kind of life. DO NO	work done Tuse retire	during most of world)	orking					
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Maryland d 2 should be file th and Mental Hy 7 is marked othe traumatic event		17. Fether's Neme (First, Middle, La	st)				18. Mother's Na	ame (First, Middle,	Maiden Surr	eme)			
Venter of the stife e	10	Stanley Zajano					Leokad	ija Unkno	wn				
and land	ľ	19a. Informant's Name/Retationship	(Type, Print)	19b.	Maiting Addr	ess (Stree	t end Number or F	Rural Route Numbe	r, City or To	or Town, Stete, Zip Code)			
C = N -		Ronald J. Smith		1	21 Ste	vens	Rd. Ri	sing Sun,	MD 21	911			
Saltimore, bemit. Pages 1 a Department of Her mportant: if item nny injury or othe ance.		20a. Method of Disposition 1 💢 Burial 2 ☐ Cremation 3	□Bamaual (same Chata	20b. Placa of cemeter	Disposition (f	Name of or other pla	ce)	Date	20c. Locatio	n - City or To	wn, Stat	.0	
Peg nent int: H		4 Donation 5 Other (Spe						6-29-99	Sprin	ahield	. PA		
Don't Port		21. Signature of Pynerat Service Lic	ensee	A	22. Name	and Addre	ess of Facility			y (I co ca	, , , ,		
n agesa		12/11	10.	13	K. I.	Foar	id funero	il Home,	P.A.				
		23a. Part . Enter the disease, och shock, or heart failure. List on	mplication what caused	e death. Do n	ot enter the m	node of dyl	ng, such as cardie	ac or respiretory ar	un, Mi rest,	21911	Approxi	imate	
Physician		snock, or neart failure. List on	ly one cause on each e	Ť							Onset a	Between and Death	
		Immediate Cause (Final disease or condition	COL	ICECTI	11C H	GAT.	FAILU	05			2	Anyc	
Examiner		resulting in death)	a	Due to (or as a c			1 1/20	42			d	DAYS	
	ner		DU				27 614510	246			1.	YEAR	
Suted	au.	Sequentially list conditions,	ь.	Due to (or as a c			C/ 12/43/C	<i>,,,</i> 4		1	-	/12/	
o an ar riel-t-leir		if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	05	NAL	and the same	,					1 .	YEAR	
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ntifice ng ph	Med	resulting in death) Last		,	,								
BOX ath cert stendin for use	Z and		d							i			
deat deat	Sicia	Part II. Other eignificant conditions	contributing to death be	ut not resulting In	the underlyin	g cause gi	ven in Part I.	23b. Did t	obacco use	contribute to	the cau	use of death?	
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The The Ide his	TO.							1□ Y	es 2 No	1□	Yes	2□ No	
		25. Was case referred to medical					26. Place of De	eath (Check only or	ne)				
ysicl is ce direc	0	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☐ Inpatie	nt 2□ER/Out	patient 3	DOA Ott		Home 5 ☐ Resid		Other (Specify	()		
		27. Manner of Death	28a. Date of Inju (Month, Da	ry 28b. T	ime of	28c. Inju Wo		28d. Describe h					
ath. r: Aff	atio	1 Anatural 5 Pending 2 Accident Investiget		7 1047)	М		Yes 2 □ No						
DIVISION all or Attending s efter death. al Director: After ed in by the fune	Certific	3 ☐ Suicide 6 ☐ Could not determine		ury - At home, far c. (Specify)	m, street, fact	tory, offica		28f. Location (S City or Tow	treet and Nu n, State)	mber or Rura	Route f	Number,	
Hospit 24 hour Funera		29a. Certifier 1 Certifying I (Check only one)	Phyeician: To the best of aminer: On the basis of and manner ste	exemination and	death occurre l/or investigati	ed at the ti	me, date and place	ce, and due to the courred at the time, o	ause(s) end lete end plac	manner as sta e, and due to	ated. the cau	se(s)	
o the o the omple	Me	29b. Signatule and title of certifier	A A	20 2002	1	29c. Dicens	se number		29d. Date sig	ned (Month, L	Dev. Yes	ar)	
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10		Macque	AM	ruly	IN	110	2485		6/	27/7	7		
10		30. Name end eddress of person wh		eath (Item 28a) (	Type, Print)	LA AC	11/1-	ULLDING		3 4 4	, , 6	21034	
		MALCOL  31. Date filed (Month, Day, Year)		HILLIF	> 1	MAS	UNIC B	VILDING	DA	LUNGTO	14	MO	
St	ate	IIIII 9 Q 1000	32. Hegistra	ar's Signature	1	,							



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State of Maryland / Department of Health and Mental Hygiene  $\mathbb{Q}$ Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month Physician 10.30 AM MARY **EMMA** 26 SHIFLETT June 1999 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 29 Hollingsworth Manor E1kton Ceci1 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Deys Hours Months 80 Director 213-16-9090 September 2, 1918 Delaware Usuel Residence of Decedant 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23a of 266-f show the Medical Examiner must be notified at 1⊠ Yes 2 No Director Maryland Cecil E1kton 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? ŧ 21921 Funeral 29 Hollingsworth Manor United States 12. Wes Decedent Ever In U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, atc. 72 hours after 1 ☐ Never Merried 2 ☐ Merried White Maryland 21215-0020 1 Yes 2 No Specify: Specify: 20 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Government Veterans Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 10 Medical Center Nursing Aide permit. Pages 1 and 2 should be filed Department of Health and Mental Hygie Important: If Item 27 is marked other 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 88 10 George Gardner Rosa Reed 19e. Informent's Neme/Raletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) James F. Shiflett / Son 106 Bowling Lane, Elkton, MD 21921 Baltimore, 20e. Mathod of Disposition 20b. Place of Disposition (Name of cemetary, cremetory or other place) 20c. Location - City or Town, State Dete June 29 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Steta b 4 Donation 5 Other (Spee 1999 Worth East Methodist Cem. North East, Maryland 21. Signature of Funeral Service Lice 22. Name end Address of Fecility Crouch Funeral Home 127 South Main Street, North East, MD 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intarval Batween Onset and Death **Physician** /Medical Immediate Cause (Final diseesa or condition resulting in death) Examine Examiner 4Bus Coronary death certificate be executed physician and the burial-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Duene (or es a consequence of): Physician/Medical Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Onknown signed t by 24b. Wera autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed Deen certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medicel axeminar?
1 ☐ Yes 2 ☑ No Be 28. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Pasidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury st Work? 5 Pending investigation After Attending 1 (9Natural death. 1 Yes 2 No 2 Accident or Attend after death Director: / 6 Could not be datermined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital edical 29e. Cartifier 112 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, date and place, and due to tha cause(s) and mannar as stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) Jackele Smr 023322 30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

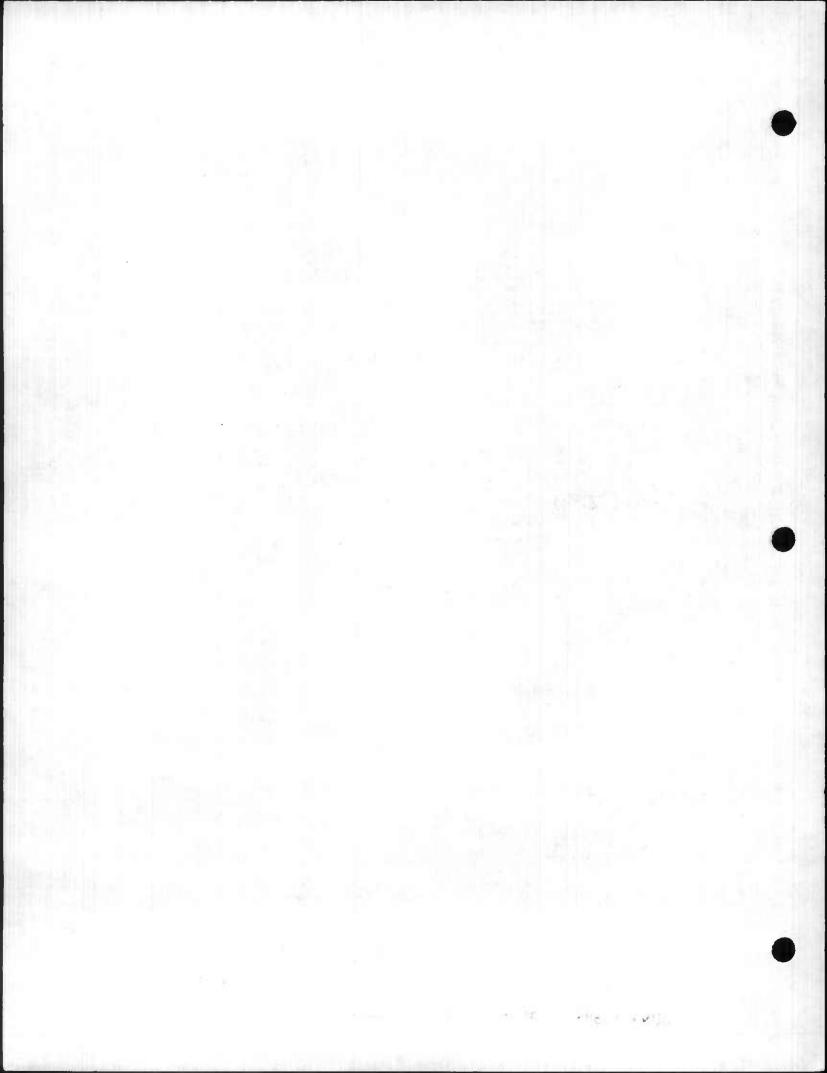
Sech Let MD. 118 North St 118 North St Suit 3B, Elk Con MD 21921 31. Dete filed (Month, Day, Year) 32. Registrer's Signature

**DHMH 16 Rev 6/95** 

State

Registrar

JUN 2 8 1999



## Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Deeth 3. Time of Death **Physician** Month Sara E. Saunders June 24 1999 8:50 PM /Medical 4e Facility Nama (If not Institution, giva street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner Sunrise Care & Rehabilitation Center Cecil Elkton 8. Data of Birth (Month, Day, Year) Dec. 7, 19 If Undar 1 Year Months Days If Under 24 Hrs. Birthplaca (Stata or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Hours 1 M 2 F 1908 Director 221-12-4788 90 Pennsylvania Usual Rasidanca of Dacedant 10a Stata 10b. County 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 1 Yes 2 No Director Delaware New Castle Newark 10e. Street and Number 10f. Zip Coda 10c. Citizen of What Country? 8 Berrs 23s 10 Ridge Avenue Funeral 19711 USA 12. Was Decedent Ever in U,S Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indien, Black, Whita, atc. 11. Marital Status hours after 1 Never Marriad 2 Merried 1 ☐ Yas 2 ☒ No If Yas, Giva natural, or Saltimore, Maryland 21215-0020 1 Yas 2 No Specify: 3 Widowed 4 □ Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filed within 72 l Dopartment of Health and Mental Hygiene. Important if Item 27 is merived other than "nets any injury or other treatments event, the Medica Elementery/Secondary (0-12) College (1-4or 5+) Food Services University of DE 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Harry McEwing Alice Pickles 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zio Code) Frederick Saunders/Son 10 Ridge Avenue Newark, DE 19711 20b. Placa of Disposition (Nama of cametery, cramatory or other placa) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Removal from State White Clay Creek Cemetery 6-28-99 Newark, Delaware 4 ☐ Donation 5 ☐ Othar (Specify) R. T. Foard Funeral Home, P. A. 21. Signature of Funaral Sarvice Licensae uchara re 111 S. Queen St., Rising Sun, MD 21911 23a. Parti. Entar the disease, or comblications that caused the deeth. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tntarval Between Onset and Death **Physician** Dementia of Alzheimers Type /Medical immegiata Causa (Final disaasa or condition rasulting in deeth) Examiner Examiner hysician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate causa. Entar Undarlying Cause (Disease or Injury that initiated avants rasulting in death) Last Dua to (or as a consequanca of): P.O. Box 68760. Physician/Medical Dua to (or as a consequence of) USB 88 Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 2 Onknown Records, þ ate has been signe page 2 should be 24b. Wera autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 Yas 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vitai Hospital or Attending Physician: director. 25. Was casa rafarred to madical 26. Placa of Death (Check only ona) Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 1 Yes 2 No edicai Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After 1 (PNatural 5 Panding invastigation within 24 hours aftar death. To the Funeral Director: A 1 ☐ Yas 2 ☐ No 2 Accidant lilled in by the 3 Suicida 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) 4 Homicide 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

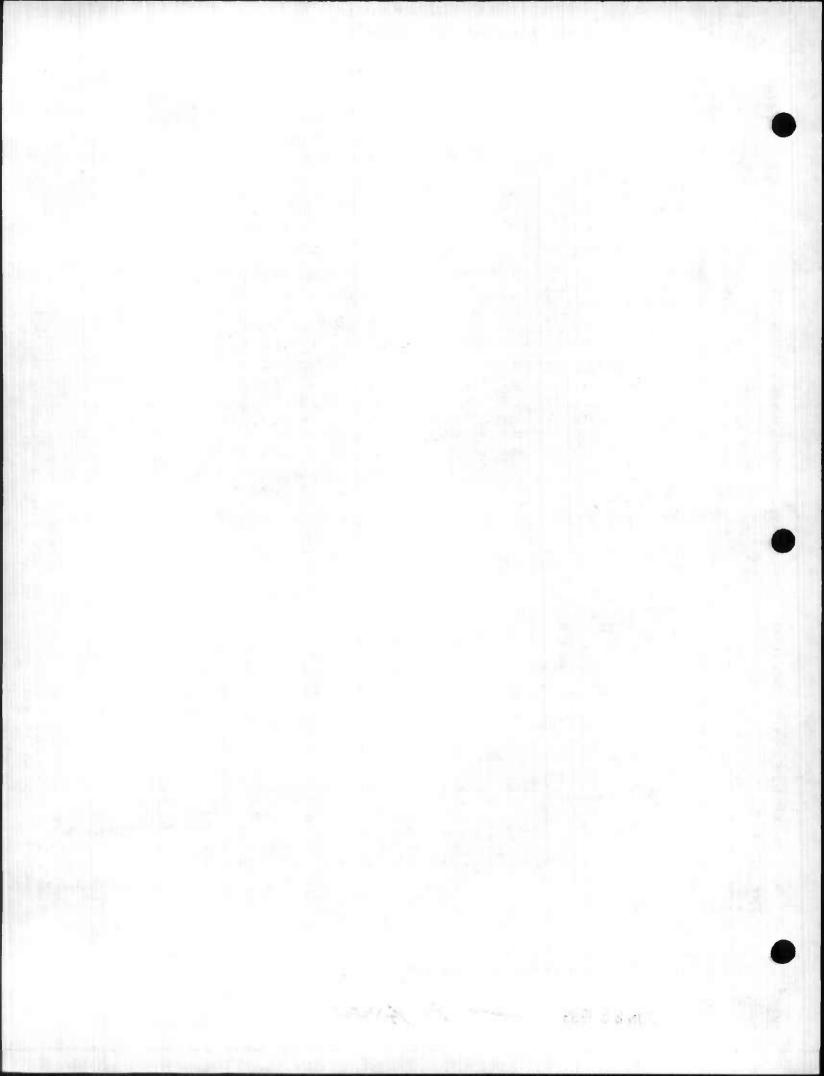
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completaly \$ 29d. Data signad (Month, Day, Year) 29b. Signetura end titla of certifiar 29c. License number 0 Sachder SMD 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) S.S SACHDEV MD. 118 North St., 8 inte 3B, Electon MD2/98/ 31. Data filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 2 8 1999

DHMH 16 Rev 6/95

#### Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 2 1 4 0 7

DIVIDEIX 0	11.0		Certificat	ic or i	Jeani		Reg. No.	-					
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/Medical Examiner	4a Facility Name (If not institution, gi				b. City, Town, or	Location of Deat			3:35 PM.				
4	RT. 295 NORTH			r 1 Year	Gambri:								
Funeral Director	5. Social Sacurity Number 218-72-1763	9. Birthpl Count	Cd .										
pua M	Usuel Residence of Decedent  10a. State 10b. County Delaware New	10c. City,	Town or Location					10	d. Inside City Limits				
Sa-f shooting	Delaware New	Castle Castle	Bear						1 Yes 2 No				
itiar death with the Maryland reterms 23a or 28a-1 show direct must be notified at Funeral Director	109. Street and Number 1030 Rue M	ſadora	10f. Zij	Code 1	9701		10g. Citizen of V USA		hat Country?				
permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Marylar Department of Health and Mental Hygiene. Important: if Itam 27 ia marked other than "natural", or items 23s or 28s-f show any injury or other traumatic avent, the Medical Examiner must be notified applied. To Be Completed by Funeral Director		12. Wes Decedent Ever in U,S Armed Forces? 1 Yas 2 No If Yes, Give Year or Datas:	. 13. Wes Dece If Yes, spe		spanic Origin? (S n, Mexican, Puer Specify:	pecify Yes or No o Rican, etc.)	14. Race Blace Specify	e - America k, White, e Wh					
2 hou	15. Decedent's E	ducation	16a. Decedent's Usu	el Occupa	ation		16b. Kind of Bu	siness/Industry					
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Mental Hyginarian Hyginarian American American To Be Co	Robert W. Sr.	1)				ne (First, Middle	, Maiden Sumam	e)					
and 2 should salth and Men n 27 is marke er traumatic	19e. Informent's Neme/Reletionship (Type, Print)  19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Robert W. Snyder, Sr. Father 204 Newark Ave., Elkton, Md. 21921												
Pages 1 and nent of Health int: if Itam 27 iry or other ti	20a. Method of Disposition  1 X Buriel 2 Cremation 3 I  4 Donetion 5 Other (Speci	City or Tov	or Town, State										
permit. Pag Department Important: It any injury o	21. Signature of Funeral Service Lice		22. Name e		s of Fecility	259 e Elkto							
	23a. Pert1. Entar tha disease, or con shock, or heert failure. List only	nplications thet caused the death.							Approximate				
Physician /Medical Examiner	Immediate Ceuse (Finei disaase or condition resulting in deeth)  a.   WWW WW TWW TWW TWW TWW TWW TWW TWW TW												
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that the death ed by the atte detached for Physicia	Pert II. Other significant conditions	t II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.							the cause of death?				
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tal or Attending P is after death. Is Director: After ted in by the funers Certification:	3 Suicide 6 Could not lead to determine determined	building, etc. (Specify)	ne, ferm, street, fector	y, office		28f. Location ( City or To	Route Number,						
To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7		hysician: To the best of my knowl miner: On the basis of examinetic					cause(s) and ma	nner as st					
To the within 2 To the complet	29b. Signature end title of certifier	end manner stated.	W 29	C. Licenso	number C.M.E.		29d. Date signed JUNE 22						
8	30. Name and address of person who	completed cause of deeth (Item 2		reet	. Baltim	ore. Mai	vland 2	1201					
State	31. Data filed (Month, Day, Year)	7-01	40		, area Call	, 1141	7						
Registrar	JUN 2 3 1999	32. Registrer's Signety	. sport	2									



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Mary E. Smith June 22 1999 8:30 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Residence: 28 Stayman Drive Port Deposit 8. Date of Birth (Month, Day, Year) April 25,1944 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1□M 2ÅF Months Days Hours Maryland 220-42-9481 55 Director Usual Residence of Decedent the Maryland pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or flems 23s or 28s-f show any Injury or other treumatic avant, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Insida City Limits Port Deposit 1 Yas 2 No Director Ceci1 Maryland 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 21904 U.S.A. 28 Stayman Drive Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, Whita, etc. 1 Nevar Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grads completed) Elementery/Secondery (0-12) Twelve Years College (1-4or 5+) Homemaker Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 Mary Alice Buskirk Willard Whiteman 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 28 Stayman Drive, Port Deposit, Maryland Patrick Smith (son) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State R.A. Ferris & Co., Inc. 6/23/99 West Chester, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licep 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home tatteren, Jr. Perryville, Maryland 21903-0188 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical year Examiner Due to (or as a consequence of) Physician/Medical Examiner physician and the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be Due to (or as a consequence of) 980 23b. Did tobacco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yea 2 No 3 Probably 4 Onknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy page 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ₺ Residence 6 ☐ Other (Specify) 10 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury et Work? After or Attending 5 Pending investigation s effer des. 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide filled in t To the Hospital o within 24 hours af To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) end manner stated. 29a. Certifier edicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifian TION650M 00093309 30. Name and address of purson who completed cause of death (item 23a) (Type, Print) Jeff Tiongson, M.D., Union Hospital of Cecil County, 106 Bow St., Elkton, MD 21921 31. Date filed (Month, Day, Year) 32. Registrar's Signature

**DHMH 16 Rev 6/95** 

Docker

Box 68760,

Smith

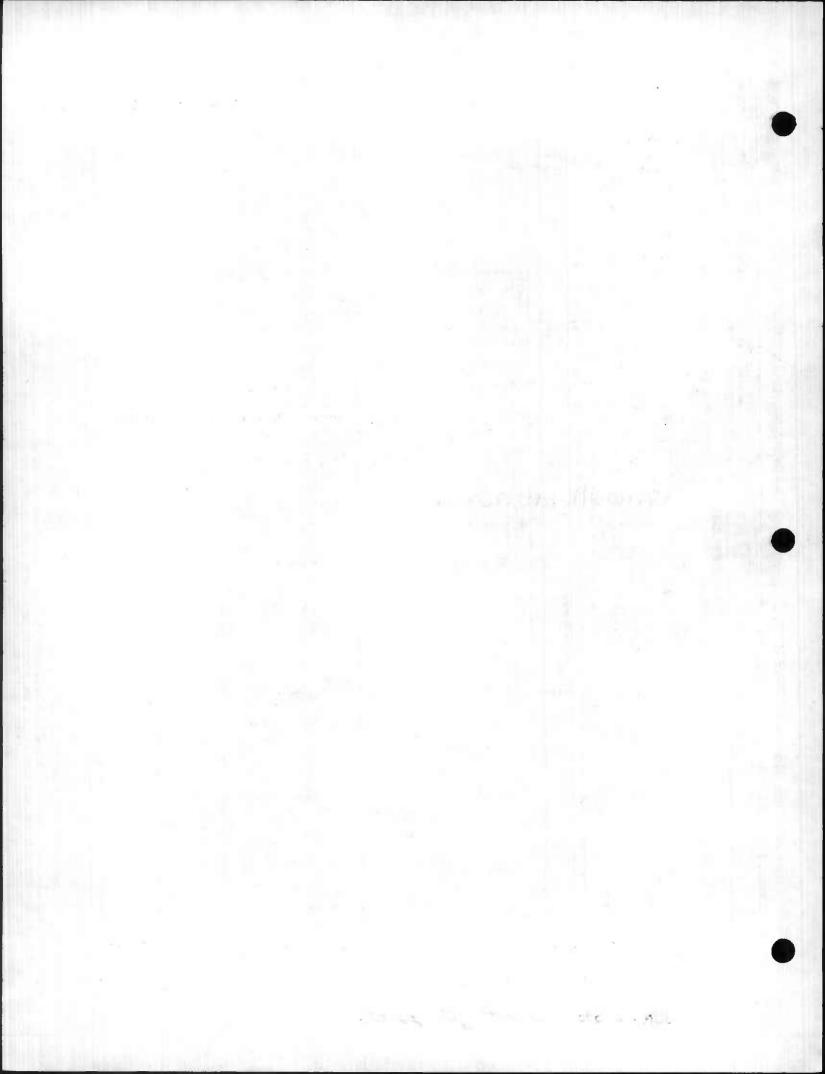
P.O. Records,

of Vital Division

State

Registrar

JUN 2 3 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Items 23a Part I a, State of Maryland / Department of Health and Mental Hygiene Q Q & 24a, Per Phy., 6/22/99, Carroll Co., wjl Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month **Physician** 19, Joanne Amelia Shaffer 1999 12:33 am June /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Carroll Carroll County General Hospital Westminster If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Mar 13,1942 5. Social Security Number 6. Sex 9. Birthplece (State or Foreign Funerai Months Deys Hours 1 M 3 F Maryland 214-40-0641 57 Director **Usual Residence of Decedent** deeth with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flems 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Carroll Hampstead 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2890 Pelham Court 21074 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 11 Marital Status e filed within 72 hours efter de il Hygiena. other then "netural", or Nem 1 ☐ Yea 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Merried altimore, Maryland 21215-0020 White 1 Yea 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Carroll County Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Heelth and Mantal Hyglen. Importants: if New 27 is marked other that early injury or other traumatic avent, that page. Public Schools Cafeteria Worker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumame) Be Vernon Raymond Valentine Helen Dorothea Strumsky 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Vernon Shaffer, husband 2890 Pelham Ct, Hampstead, Md 21074 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Buriaf 2 ☐ Cremetion 3 ☐ Removal from State 6/23 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Park Sykesville, MD 21. Signature of Funerel Service License 22. Name end Address of Fecility Eline Funeral Home line 934 South Main St, Hampstead, Md 21074 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Interval Between Onset and Death Pulseless Electrical Activity Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner ed lat ardio my physician end the buriel-trensit that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, oronar Physician/Medical Due to (or as a consequence of) 990 23b. Did tobacco usa contribute to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 1 Yes 2 No 3 Probably 4 Onknown signed b Records. by 24b. Were autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? page 2 s 1 ☐ Yes 2 X No 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifical completally filled in by the funeral director; 8 25. Wea case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 10 1 Yes 2 No 1 Inpatient 2 PER/Outpatient 3 DOA 27. Manner of Death 28d. Dascribe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. (Check only one)

State Registrar

**DHMH 16 Ray 6/95** 

29b. Signature and title of certifie

30. Name and eddress of person

31. Date filed (Month, Day, Year)

Herbert

P. Hend

JUN 2 2 1999

295 Stones

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

MO

11.

8050 m

29c. License number

29d. Date signed (Month, Day, Year)

Ave Suite 307 Westminster MM

21157

fresh

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Q

	Certificate of Death	Reg. No.
Physician	Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year  3. Time of Death
/Medical Examiner	Martha Copper Taylor  4a Facility Name (If not institution, give street and number)  4b. City, To	6 15 1999 11:15am wn, or Location of Death 4c. County of Death
	The Memorial Hospital Easto	
Funeral Director	5. Social Security Number  6. Sex 1 M 2 F 7. Age (In yrs. last birthday)   ff Under 1 Year   ff Under 2 North   North	24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplaca (State or Foreign Country)  9. Birthplaca (State or Foreign Maryland)
2 .	Usual Residence of Decedent	
Maryla If show fied at for	10a. State 10b. County 10c. City, Town or Location  MD Talbot	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
or 28e-f		21601 10g. Citizen of What Country?
	9968 Cordova Road 21601	USA
her death ver theme 23u siner must.	11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  13. Was Decedent of Hispanic Oring the Yes, specify Cuban, Mexican	gin? (Specify Yes or No- , Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
by by	If Yes, Give 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Wildowed 4 ☐ Divorced Year or Dates:	Specify Black
ygiene. Ne than "natural, the Medical, Completed	15. Decedent's Education  16a. Decedent's Usual Occupation  (Charling only highest and a completed)	16b. Kind of Business/Industry
- Man	(Specify only highest grade completed) (Give kind of work done during most life. DO NOT use retired)  Etementery/Secondery (0-12) College (1-4or 5+)	or working
Co. the	11 5+ Teacher	Education
Be son		n's Name (First, Middle, Maiden Surname)
To B	Samuel Copper Mai	y Elizabeth Tilghman
I is my		er or Rural Route Number, City or Town, State, Zip Code)
Health Mm 27 Ober to	Joseph I., Taylor Luc and 9968 Cordova Ro	Dete 20c. Location - City or Town, State
5 2 5	1 ■ Burial 2 □ Cramation 3 □ Removal from State cemetery, crematory or other place)	200. Eddining of fown, State
dury dury	4 □ Donation 5 □ Other (Specify) Richards Memorial	06/19/99 Easton, MD
Depa Impos any is	21. Signature of Funeral Service Learning 22. Name and Address of Facility 3.2.2 East	ave 2/601
	23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as shock, or heart tallure. List only one cause on each line.	
ysician		Onset and Death
Medical aminer	Immediate Cause (Final disease or condition Renal Failure	
	Due to (or as a consequence of):	
sit e	typotension	
cien and buriel-trensit	Sequentially list conditions, if any, leading to immediate	
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physicien s the burie edical E	that initiated events resulting in death) Last  Due to (or as a consequence of):	
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I for use		
ed by the detached	Part ti. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I	
rate has been signed by the attendir page 2 should be detached for use Completed by PhysicianA	chronic Subdural Hematema	1 Yes 2 No 3 Probably 4 Unknown
neign uld be	Parkinsonism	24a. Wes an autopsy 24b. Were eutopsy findings
should should	Parkinson 1811	performed? available prior to completion of cause of death?
page 2		1 Yes 2 No 1 Yes 20 No
rector, pag		
	examiner?	of Death (Check only one)  Insing Home 5 Residence 6 Other (Specify)
r this certific aral director,	27. Menner of Death  28. Date of Injury  (Month, Day Year)  128. Date of Injury  (Month, Day Year)  129. Time of Death  120. Injury  Work?	28d. Describe how injury occurred
or death. Sctor: After by the funer Ification:	Meturel 5   Pending (Month, Day Year)   Injury   Work?   2   Accident   Investigation   M   1   Yes 2	No
ctor: All y the fu	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office	28f. Location (Street and Number or Rural Route Number,
Dire	4 ☐ Homicide building, etc. (Specify)	City or Town, State)
within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral Medical Certification:	29a. Certifler (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date an and menner; on the basis of examination and/or investigation, in my opinion, dea	d place, and due to the cause(s) and manner as stated. th occurred at the time, date and place, and due to the cause(s)
thin a the	one) and manner stated.  29b. Signature and title of commer 29b. License number	29d. Date signed (Month, Day, Year)
¥ 5 8	290. Signature Into the of control of the control o	1 /
	The state of the s	ollow
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	est Easter WD 21601
	Michael Lees, MD 219 South Washington Str	eet Easton, MD 21601
State Registrar	31. Date filed (Month, Day, Year) 32. Registrer & Signature 5. Sports	

JUN 1 FEET JUNU

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month 4:00 a.m. Peter Frank Tapke 1999 June 11 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 117 High Street Chestertown Kent If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) October 7, 1930 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Yeer Birthplace (State or Foreign Country) Months Deys 1XM 2□ F 579-46-8172 68 Washington, D.C. Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits XXYes 2 No Maryland Kent Chestertown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 117 High Street 21620 USA Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, Bieck, White, etc. 1 ☐ Yes 2 XNo 1 Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Philosphy Professor Higher Education 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) Victor Ferdinand Tapke Ruth Harriet Butts 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) James David Newell/Adminstrator 10709 Tilden Lane, Chestertown, MD 21620 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Buriel 2 X Cremetion 3 ☐ Removel from State Chesapeake Cremation Center, LLC 6/15/99 Stevensville, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Servica Licensee 22. Name end Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620 23e. Pert1. Enter the disease, or complication—that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one children is one each line. Approximete Interval Between Onset and Deeth Cardio my o pothy dilated with severe left Due to (or as a constituence of) by a function Immediate Cause (Final diseese or condition resulting in deeth) Out coholismo Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequença of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2€No 3 Probably 4 Unknown

**Physician** /Medical Examiner

certificata be exec

P.O. Box 68760.

Division of Vital

**Physician** 

/Medical

**Examiner** 

10a State

Director

Funeral

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Completed

**Funeral** 

Director

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r than "natural", or items 23a or 28a-f ehov the Medical Examiner must be notified at

the Maryland

death

permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mentel Hygiene. I hours effer timportant: If flem 27 is marked other than "natural", or flee eny Injury or other traumatic event.

altimore, Maryland 21215-0020

the bunial-transit pue physician 98 signed by the 9 peed cartificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifications and the funeral process. funeral

25. Wes case referred to medical examiner? 1 Yes 25 No 27. Menner of Deeth 10 Naturet 2 Accident Certification:

Examiner Physician/Medical à Completed Be C

chronic atrial febrillation

1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year)

5 Pending investigation 6 Could not be determined

28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

Other: 4 Nursing Home Residence 6 Other (Specify) 28b. Time of 28c. Injury at Work? 1 Yes 2 No

 Location (Street and Number or Rurel Route Number, City or Town, State) Cartifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

Inton Med 216 20

28d. Describe how injury occurred

24e. Wes en eutopsy performed?

1 ☐ Yes

26. Plece of Deeth (Check only one)

22 NO

29b. Signeture and title of cartifier

3 Suicide

29a. Certifier

4 ☐ Homlcide

29c. License number 7036 29d. Date signed (Month, Dey, Year)

24b. Were eutopsy findings aveileble prior to completion of cause of death?

1 TYes 2 TNo

30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print) Washytor 516

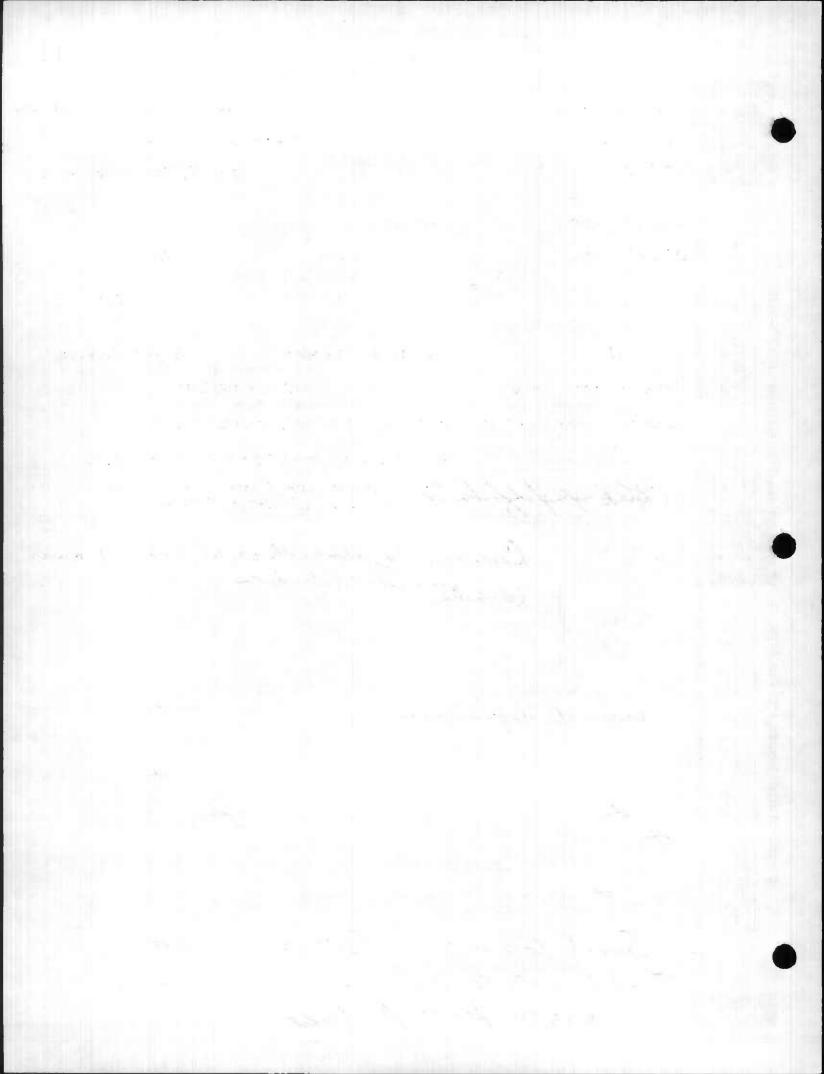
31. Dete filed (Month, Dey, Year)

32. Registrar's Signeture JUN 1

State Registrar

Medical

15



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 2, 1999 ALBERT FRANKLIN TAPMAN 2359 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1₩ 2□ F Months Days Yrs. 227-40-8276 VA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No ACCOMACK BLOXOM 10e. Street and Number BAY 10f. Zip Code 10g. Citizen of What Country? 15186 SHORE DRIVE 23308 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Yeer or Detes: 56-59 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bieck, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 WATERMAN SEAF00D 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) ISSAC HENRY TAPMAN MARY ANN PRUITT 19a. informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARIE ROWLEY 15186 BAYSIDE DR. - BLOXOM, VA 23308 20a. Method of Disposition 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stele 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKSLEY CEMETERY 6-6-99 PARKSLEY, VA 22. Name and Address of Facility 705 E. MAIN ST. blus Het BOUNDS FUNERAL HOME, INC. SALISBURY, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Rupture Septal myo cardia Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events Due to (or as a consequence of): resulting in death) Last 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown insuffice ency 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Was en autopsy performed?

**Physician** /Medical Examiner

The lew requires that the death certificate be axecuted

P.O. Box 68760,

permit. Peges 1 and 2 should be filed within 72 hours after death with I Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or in important: if item 27 is marked other than "naturel", or other treumatic event, the Medical Example must be none.

rank Tapman

**Physician** 

/Medical

Examiner

Director

Funeral

by

Completed

VA

**Funeral** 

**Director** 

Physician/Medical Examiner and -transit attending physician a for use as the burielþ Completed

Division of Vital Records, or Attending Direct in by To the Hospital o within 24 hours at To the Funeral D the Funeral D

death.

is certificate has director, pege 2 Be To this funeral Certification: After ector: A

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Registrar

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29a. Certifier (Check only

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 20 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1□ Yes 20 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Tyes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Cartifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signatupe and title of gentilier

SMO

29c. License number 153394

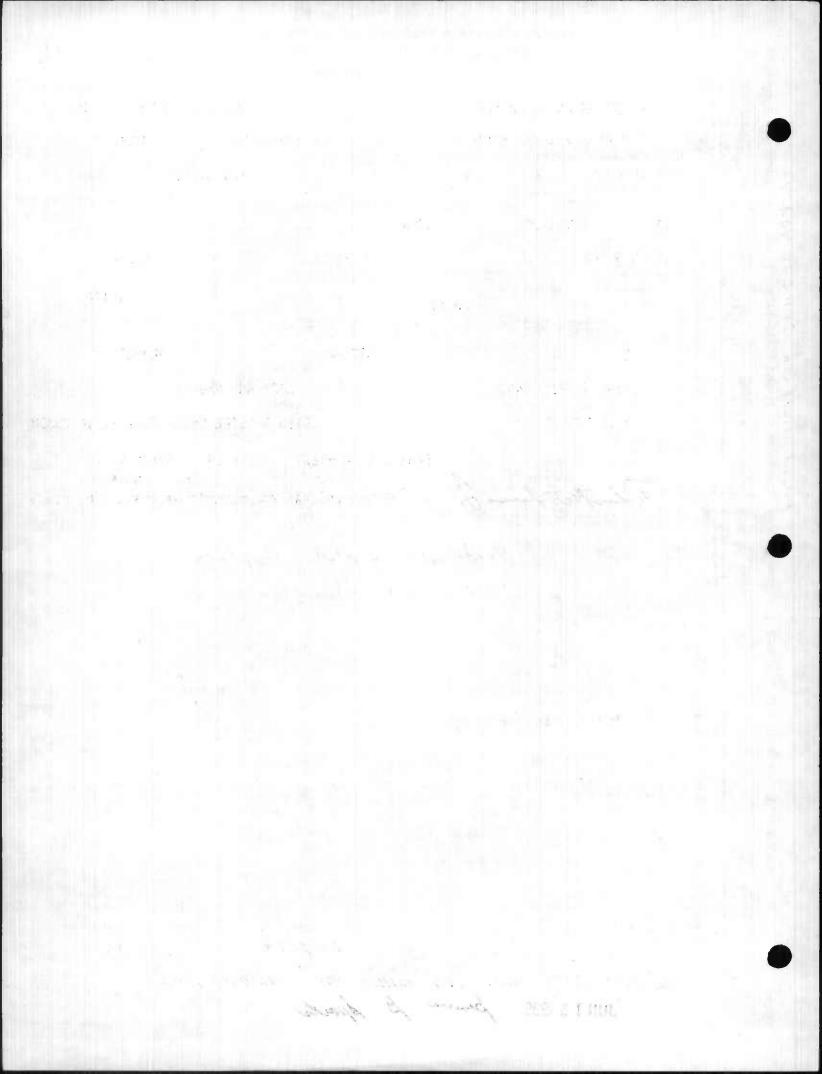
30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

ANTHONY FREY m.0. 106 milford

1 5 1999 32. Registrar's Signature

9

salisbury, mo



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene O

	1. Decedent's Neme (First, Middle,	.ast)		Certificate of	Death	2. Dete of Dae	eg. No.		3. Time of Death		
	Anne Anderso					Month June	Dey	Yeer 999	0.030 hay		
	4a Facility Nema (If not institution,				4b. City, Town, or L		4c. County				
Cammer	Harford Memoria				Havre de	Grace	Harf	bro			
erai		Sax 7. Ag	e (In yrs. last bir	thday) If Under 1 Year	If Undar 24 Hrs.				plece (State or Foreign		
	170-14-0082 Usual Rasidence of Decedent	1□ M 2XXX 8	0	Yrs. Months Deys	Hours Min.	8. Date of Birth (Month, Day Apr. 12	1919	Penr	sylvania		
	10e. Sleta 10b. County		10c. City, Town	or Location		10d. Inside City Lin					
ctor	MD Harf	ord	i	Aberdeen					¥2¥es 2□No		
Dire	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	/hat Cou	intry?		
H. B.	16 South Rogers	_			1001		U.S.	Α	iaan ladian		
by Fune	11. Marital Stelus  1 □ Never Married 2 □ Married  Widowed 4 □ Divorced	12. Wes Decedant Armed Forces?  1 Yes 251 If Yes, Give Yeer or Detas:		13. Was Decedant of If Yas, specify Cub  1 ☐ Yas 2 ☐ No		pecity Yes of No- o Rican, etc.)		k, White			
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am	Sequentielly list conditions,	D		onsequenca of):				İ	1000-1		
	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events	c	Ren	al failur	e				3 weeks		
dles	thet initieted events resulting in deeth) Last	V	Due fo (or es e o	consequence of):							
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pieted by						24e. Wes e	en eutopsy med?	6	Vere eutopsy findings vellable prior to ompletion of cause of deeth?		
E						1 🗆 Y	es 2 No	1	☐Yes 2☐No		
	25. Wes case referred to medical examiner?				26. Place of Dec	eth (Check only o	ne)				
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	27. Manner of Deeth  1 KNeturel 5 Pending 2 Accident Investigat 3 Suicide 6 Could no	he			ry et ork? ] Yes 2 □ No	28d. Describe h			rai Pauta Alumbar		
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edicai			examinetion en	dor investigation, in my							
Σ	29b. Signature and lifle of certifier			29c. Lican	sa number	1	29d. Dete signe	(Month	, Day, Year)		
	- Jung			D3	6715		JUNY 19	1,19	99		
	30. Neme end address of person wh		eeth (Item 23e)	(Type, Print)					21014		
		IM GEW		39 Church	ville f	Rd. B	el Hir	MI	21014		
State	31. Dete filed (Month, Dey, Year)	32. Registro	er's Signeture	1000	man 1	4 km	. 41				

21.75 A. J. B. B. B.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #23 PART I, PER MD G774 8-25-99 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** THOMAS DAVID WILLEY, SR. June 12 9:57 p 1999 /Medical 4a Facility Name (# not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Memorial Hospital Easton Talbot 5. Social Security Number 6. Sex 1 → M 2 → F 7. Age (In yrs. last birthday) If Under 8. Date of Birth (Month, Dev. Year) Birthplace (State or Foreign Country) Funeral Months 215-38-2320 58 Director JULY 30,1940 PENNSYLVANIA Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits t Yea 2 No Directo 28a-f. TALBOT TRAPPE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code re 23a or 29320 HOWELLS POINT ROAD 21673 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes À XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 8 1 Yes 2 No Specify: Specify: WHITE à 3 ☐ Widowed 4 🖾 Divorced Completed 16a. Decedent'a Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiana. Elementary/Secondary (0-12) College (1-4or 5+) 12 CONTRACTOR LANDSCAPE Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 1 and 2 should be Health and Mental JOHN WILLEY ELEANOR NORRIS 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Health a THOMAS D. WILLEY, JR. / SON 101 MARLBOROUGH ROAD, QUEENSTOWN, MD 21658 Saltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata Pages nent of P 1 Burial 2 □ Cremation 3 □ Removal from State OXFORD CEMETERY 6-15-99 OXFORD, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 111 FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Dua to (or as a consequence of): Physician/Medical Examine hysician and the burial-transit un The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, SEPSIS Due to (or as a consequence of) USB BS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown Records, þ Completed 24a. Was an autopsy performed? 24b. Wera autopsy findings available prior to completion of cause of death? Dage 2 1 Yes 2 No 1 ☐ Yas 2 ☐ No of Vital Physician: 25. Was case referred to medical examiner? Be 26. Piaca of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this uneral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Division or Attending s after death. 1 Yes 2 No 2 Accident the 6 Could not be determined 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 6 4 | Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the besis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) 29a. Certifie Medical

State Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

STANLEY M. BYSSHE,

Medical Examiner: On the besis of examiner and manner stated.

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)



JR., M.C., 505 DUTCHMAN'S LANE, EASTON, MD 21601

29c. License number

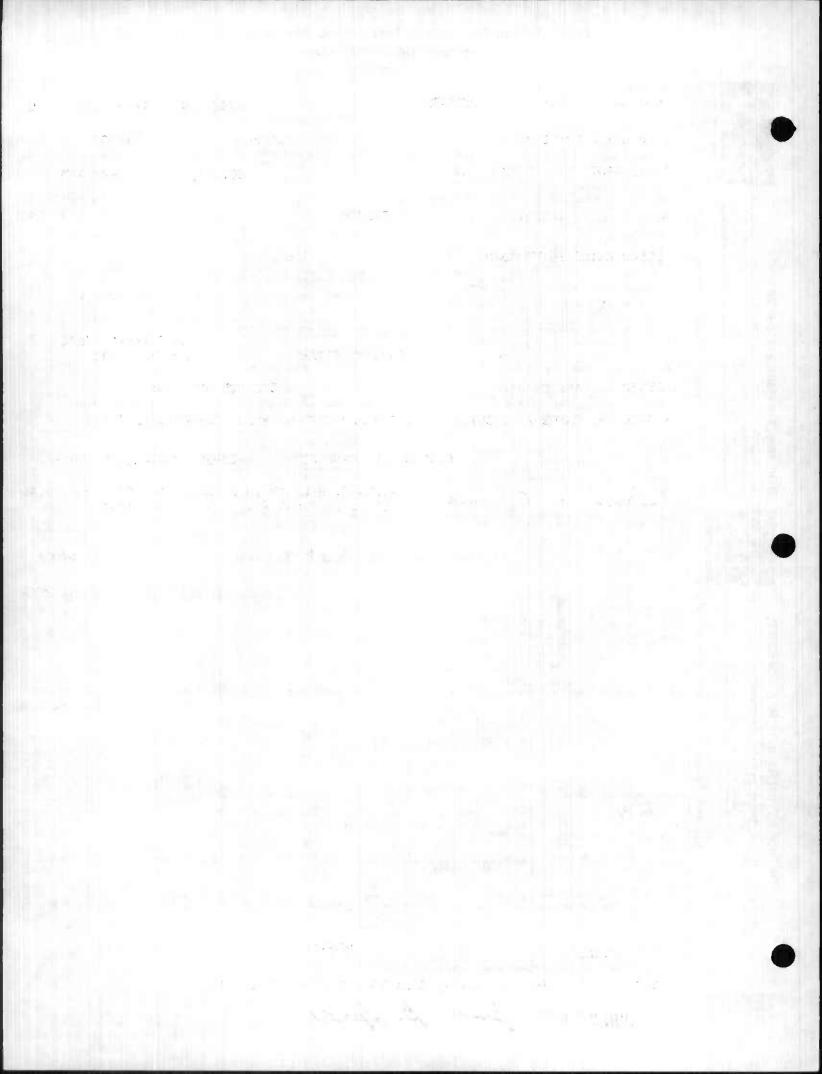
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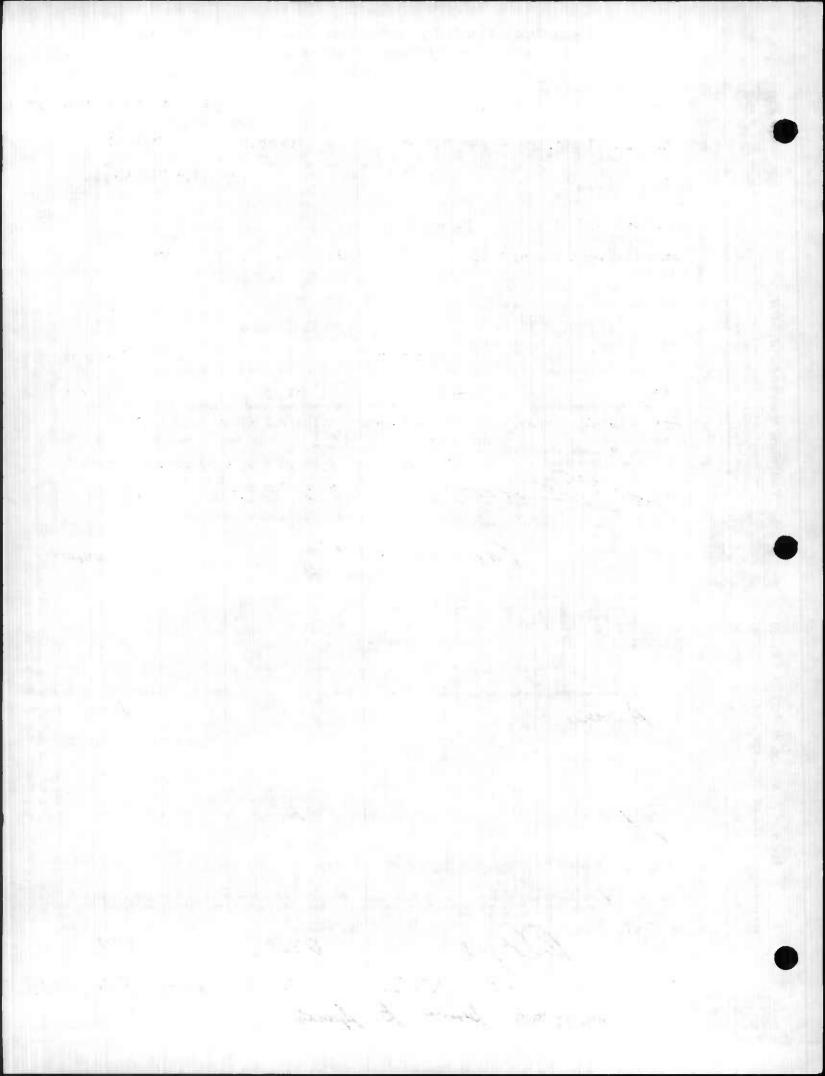
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State	31. Dete filed (Month, Dey, Ye		Registrar's	Signeture	,	9 km	200				,		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month June 9, 5:00 p.m. William Barnaby Willis, III 1999 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death 549 Fey Road (Residence) Chestertown Kent If Under 24 Hrs. 6. Date of Birth (Month, Day, If Under 1 Yeer Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (in yrs. lest birthday) Days 1⊠M 2□ F Months 61 Yrs. October 18, 1937 218-34-3070 Chestertown, MD Usuai Residence of Decedent 10e. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Maryland Queen Anne's Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 549 Fey Road 21620 USA 12. Was Decedent Ever in U,S. Amed Forces? 1 ☑ Yes 2 ☐ No If Yas, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11. Maritai Status 1 Never Married 200 Married 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 Coilege (1-4or 5+) Postmaster U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) William Barnaby Willis, Jr. Anna Cook Coleman 19a. informant's Neme/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Jewell Willis/Wife 549 Fey Road, Chestertown, MD 21620 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 ☐ Buriai 2 【Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation Center, LLC 6/11/99 Stevensville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Fellows, Helfenbein & Newnam Funeral Home, P.A. 23a. Part 1. Enter the ustress, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart fail are. List only one cause on each line. Approximata Interval Between Onset and Daath Immediata Causa (Finai CARDIO pulmonary Annest disease or condition resulting in death) Responde fam.
Due to (or as a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Part ti. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown Right uppen labe concernous with all trostotic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Brain, To BAZEO More, airduste desire to 155tony plannary arting Desire with 1 Yes Alcoholost, 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Hospital: 1 | Inpatient 2 | ER/Outpatlent 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred

**Physician** /Medical Examiner physician and the burial-transit The law requires that the death certificate be executed P.O. Box 68760

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

Funeral Director

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Completed

Be

filed within 72 hours after death with the Maryland

altimore, Maryland 21215-0020

Pages 1 and 2 should be frank of Health and Mental I inter 27 is marked of

or other t

Examiner signed by the a Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica staty filled in by the funeral director; §

Physician/Medical þ Completed Be Certification: To To the Hospital or within 24 hours aft To the Funeral Discomplataly filled in Medical

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Division of Vital Records,

25. Was case referred to medical examiner?
1 Yes 2 PNo 27. Manner of Death 1 Naturai

2 Accident

3 Suicide

29a. Certifier

4 Homicida

(Check only one)

5 Pending investigation

6 Could not be datermined

None 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier MO wells

29c. License number 123889 29d. Date signed (Month, Dey, Year)

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)

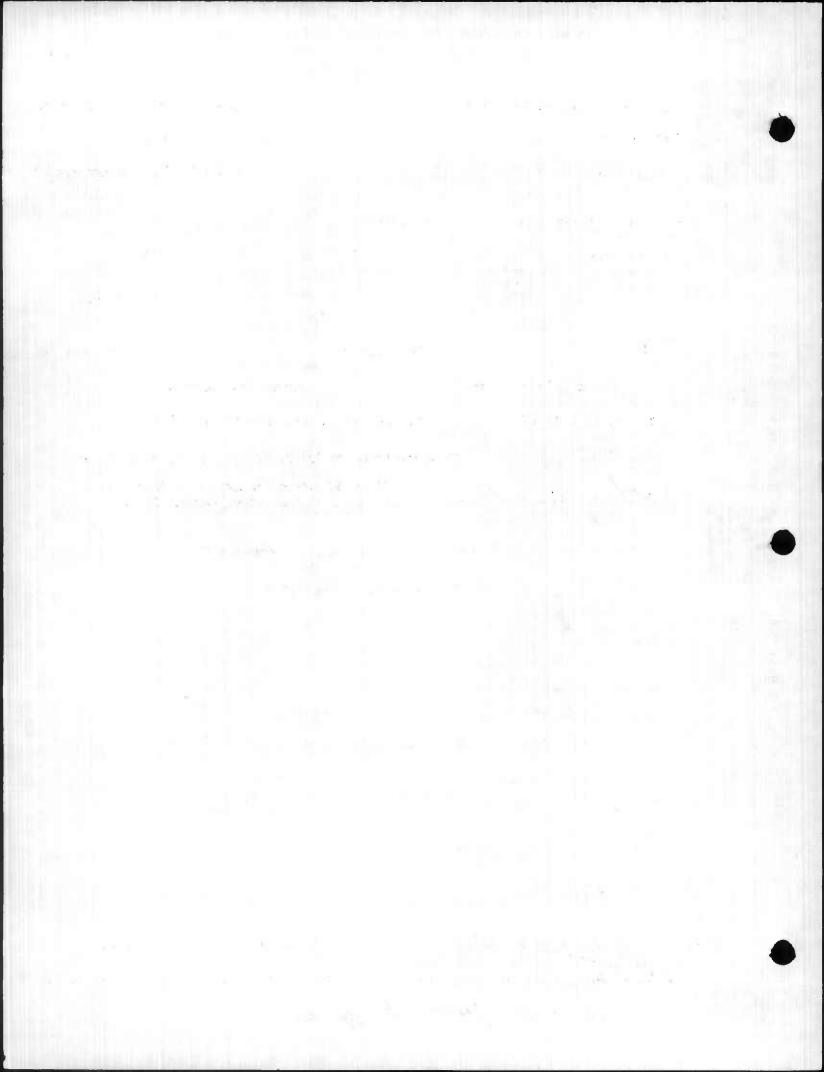
948 WAShington John C. ARRAIS DE M. M.S.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Ave, Chester form, med 21620

Registrar



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey **Physician** MILDRED MATERS OU SE 17, 1995 4c. County of Death 1447 June /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner WICOMICO SALISBURY PENINSULA REGIONAL MEDICAL CENTER 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 39 5. Sociel Security Number 9. Birthplace (Stete or Foreign Country) **Funeral** 1 M 2 KF 214-32-1566 Director Usuel Residence of Decedent 10e. Stete 10d. Inside City Limits toc-City. Town or Location items 23a or 28a-f show the must be notified at 1 X Yes 2 □ No Director OMERSET Rincess MINE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21853 11281 JREEN WOOD School RD Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes: 14. Rece - American Indien, 11 Meritel Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. traumatic event, the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Black p 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) INDUSTRY AboRER 18. Mother's Neme (First, Middle, Meiden Sumeme) Father's Name (First, Middle, Last) Be nthony MATERS UVENIA JONES 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) eletionship (Type, Print) permit. Pages 1 end 2 s Department of Health at Important: If item 27 Is any injury or other treu Dorothy 11281 Apt. 3 Greenwood School RD Princess Anne UD 21853 20c. Location - City or Town, State WATERS JONES 20b. Plece of Disposition (Neme of cemetery, cremetory or other) 20e. Method of Disposition Dete 1 Surial 2 ☐ Cremetion 3 ☐ Removel from State 6-23-99 Princess 4 ☐ Donetion 5 ☐ Other (Specify) Cemetry Wesley ohn Anthony E. Wald Funcial Home 21. Signeture of Funeral Service Licensee 30439 Hampden tre. Princess Anno. 21853 MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Ooset and Deeth **Physician** Immediate Ceuse (Finel diseese or condition resulting in deeth) /Medical Se 2 days Examiner (or es e consequence of): Due to Examiner 2012/65 attending physician and for usa es the burial-transit Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In deeth) Lest Due to (or es e conseguente de Slucie Physician/Medical Due to (or es e consequence of): 88 ed by the a Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 | Yes 2 No 3 | Probably 4 | Unknown by 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24e. Was en eutopsy periormed? Completed page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese referred to medical Be 26. Plece of Deeth (Check only one) s efter death. al Director: After this cr Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the dasth certificats be axecuted Box 68760. P.O. Division of Vital Records. Physician: or Attending within 24 hours e To the Funeral C completely lilled Hospital

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29a. Certifier

(Check only

29b. Signeture end title of certifier

31. Dete filed (Month, Day, Year)

Registrar

JUN 2 1

29c. License number (aw

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1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner as steled.
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and menner stated. 29d. Date signed (Mgnth, Day, Year)

30. Neme end address of person who completed ceuse of death, (Item 23e) (Type, Print)

1999

BENITO

32. Registrer's Signature

WEIGHT SCHILL Bund seemed Transport UM Colle Grind - assessment Fug. 12010 Manual A. Canal C Addata ZABIRA RECORDS

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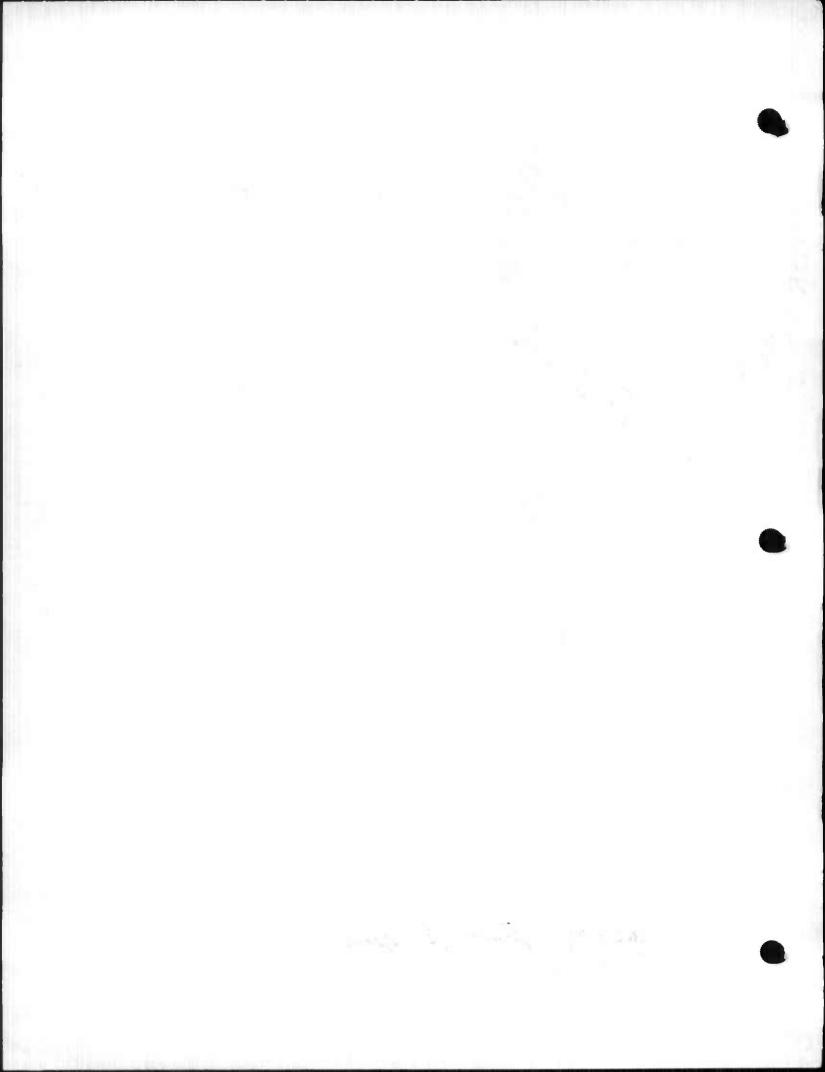
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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

FOR STATE REGISTRAR	STATE OF MARYL				too I I b			
1. OECEOENT'S NAME (First, Middle, Last)  Marie	Virginia	Wil	ling	2. DATE OF DEATH MONTH DAY	3. TIME OF OEATH  9:12 PM. M			
4. SOCIAL SECURITY NUMBER 215-58-5542	5. SEX 6. AGE	(In yrs. last birthday) IF I	UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year) 01/24/1913	a. BIRTHPLACE (State or Foreign Country) Maryland			
Princes Anne 50 me								
Maryland Somer				10d. INSIDE CITY LIMITS?  2- YES 2 NO				
		101. ZIP CODE 21853		10g. CITIZEN OF WHAT COUNTRY?  USA				
11. MARITAL STATUS 1 Never Married 2 Married 3- Wildowed 4 Divorced	2 NO	If yes, specify Cuban, Mexic	can, Puarto Rican, etc.)	Bleck, White, etc. Specify:				
(Specify only highest grade Elementary/Secondary (0-12)	CATION completed)  Coffege (1-4 or 5 +)	(Give kind of work a life. Do NOT use reti	done during most of working	16b. KIND OF BUSIN				
17. FATHER'S NAME (First, Middle, Last)	_	пооземтте	18. MOTHER'S N					
John Smith					,			
The second secon								
20a. METHOD OF DISPOSITION  1 Buriel 2 Cremation 3 Rem  4 Donation 5 Other (Specify)	oval from State 20b	PLACE AND DATE OF DIS	SPOSITION (Name of	DATE 20c. LOCA	TION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LIN	DENSEE Mad	A	22. NAME AND ADDRESS OF F Hinman Funera	1 Home	21853			
23 MRT I. Enter the diseases, or ahock, or haert fellure.	complications that caused List only one cause on a	the death. Do not e	nter the mode of dying, su	ch as cardiec or reapira	tory erreet, Approximate Interval Between			
IMMEDIATE CAUSE (Final disease or condition Prumonia								
DUE TO (OR AS A CONSCOUENCE OF):								
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):	alilate a l		1			
CAUSE (Disease or Injury that initiated events resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE OF):	sofene en	cw(o(cc	4 weeks			
PART ii. Other significent condition	s contributing to deeth b	ut not regulting in th	a underlying cause given i	Part I Gas MESANAN				
			a unuanynig cause given ii	PERFORME  1 TYES 2	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YES [	□ NO □ UNCERTA	IN 🗆	1 TYES 2 NO			
EXAMINER?	HOSPITAL:	ON	HER:					
27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME OF	28c. INJURY AT	6 Other (Specify)  28d. DESCRIBE HOW INJ	URY OCCURED			
Natural 5 Pending 2 Accident Investigation			M 1 YES 2 NO					
4 Homicide detarmined	building, atc. (Spec	— At nome, tarm, street.	, factory, office	281. LOCATION (Street and City or Town, State)	Number or Rural Route Number,			
(Check only	CIAN: To the best of my knowledge.  R: On the basis of examination	edge, death occurred at and/or investigation, in	the time, data and place, and du my opinion, death occured at th	e to the cause(s) and manne e time, date and place, and d	r as stated. fue to the cause(s) and manner as stated.			
4 . 6 / 1 ~ /		AN			9d. DATE SIGNED (Month, Day, Year)			
29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)  DR - US IFA NATES AN  30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)								
DR-CLSHA NATESAT	V 201 HAL	c Hathra	MADIE AL	V 11 - 21 - 21	CRISFIELD MUZISI7			
	1. OECEOENT'S NAME (First, Middle, Last)  Marie  4. SOCIAL SECURITY NUMBER  215-58-5542  9a. FACILITY NAME (If not institution, give in the continuous in the count of the cou	TATE REGISTAR  1. OECEOENT'S NAME (First, Middle, Last)  Marie Virginia  4. SOCIAL SECURITY NUMBER  2.15-58-5542  9a. FACILITY NAME (If not institution, give atreet and number)  Maryland Somerset  10a. STATE  10b. COUNTY  Maryland Somerset  11. MARITAL STATUS  11. Never Married 2 Married  2. Married  2. Married  3. SEX  1 M 2 M 5 R 8  8. AGE, 8  8. AGE, 1 M 2 M 5 R  9. AGE, 1 M 2 M 5 R  9. AGE, 1 M 2 M 2 M 5 R  9. AGE, 1 M 2 M 2 M 2 M 5 R  9. AGE, 1 M 2 M 2 M 2 M 2 M  9. AGE, 1 M 2 M 2 M 2 M 2 M  9. AGE, 1 M 2 M 2 M 2 M 2 M  9. AGE, 1 M 2 M 2 M 2 M  9. AGE, 1 M 2 M 2 M 2 M 2 M  9. AGE, 1 M	STATE REGISTRAR  CERTIFIC  1. OCCEOENT'S NAME (First, Mickie, Lest)  Marie  4. SOCIAL SECURITY NUMBER  2.15-58-5542  1. Mary Residence of Name	1. STATE PRINTED TO PERTINENT OF PERTINENT O	STATE OF MARKET OF HEALTH AND MENTAL HYBERE REGION OF DEATH REGION AND ADDRESS OF PARTY MARKET OF HEALTH AND MENTAL HYBERE REGION OF DEATH REGION OF THE PARTY HAND MENTAL HYBERE REGION OF THE PARTY HAND MENTAL HYBER REGION OF THE PARTY HAND MENTAL HYBERE REGION OF THE PARTY HAND MENTAL HYBERE REGION OF THE PARTY HAND MENTAL HYBER REGION OF THE PART			



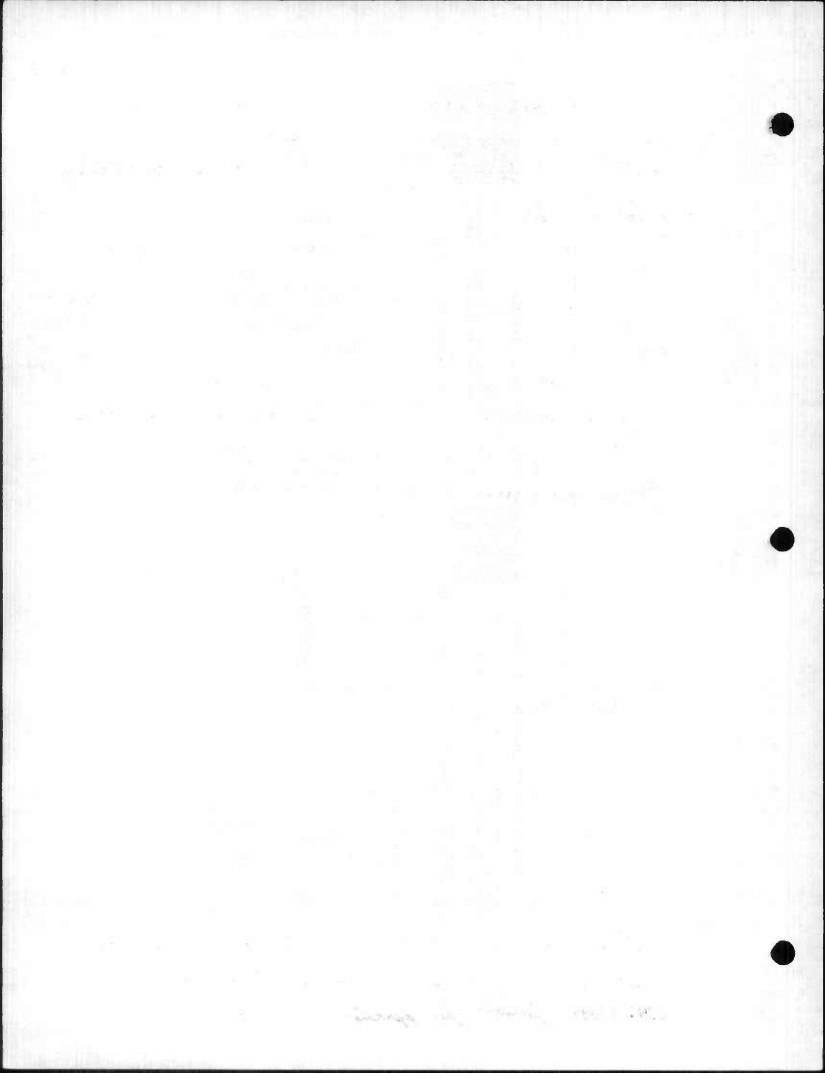
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State of Maryland / Department of Health and Mental Hygiene

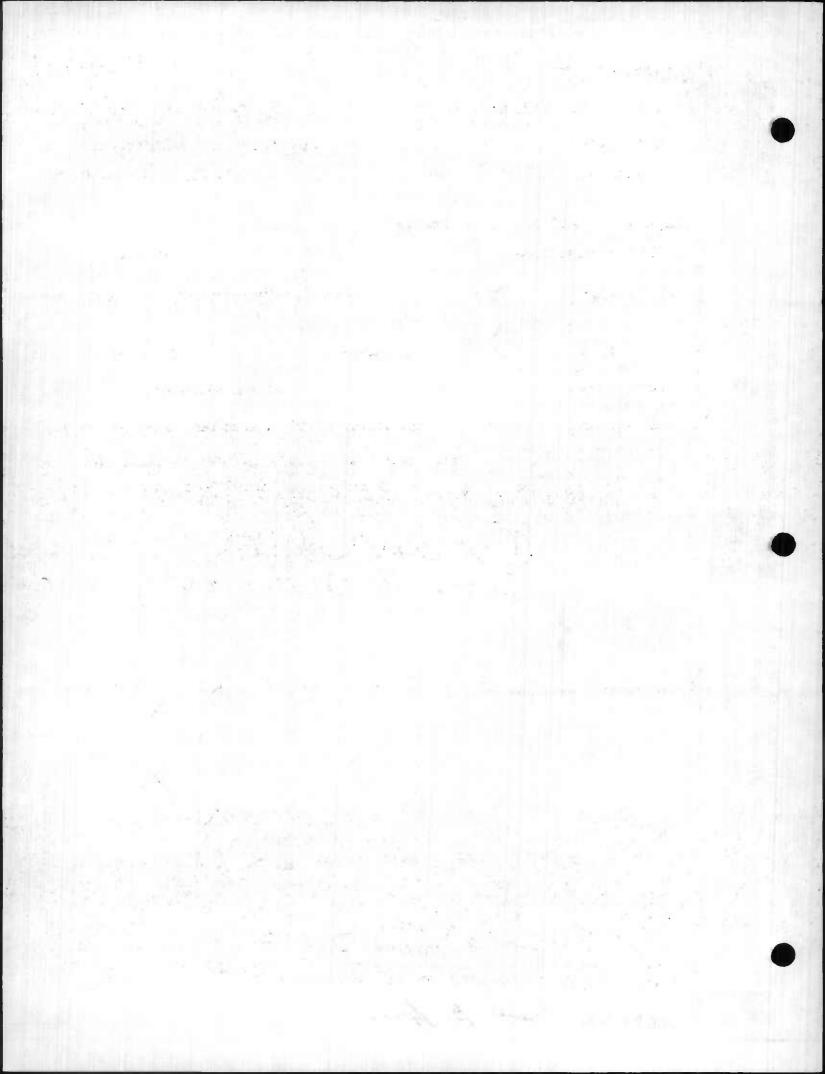
Certificate of Death 1. Decedant's Nema (First, Middla, Last) 2. Date of Deeth 3 Time of Death Month **Physician** June 0700 Pearl Kathleen Wells /Medical 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Sunrise Care & Rehabilitation Center E1kton Cecil 5. Social Security Number 7. Aga (In yrs. lest birthday) If Under 1 Yeer 8. Deta of Birth Month, Day, Year) Feb. 11,1916 9. Birthplece (Stete or Foreign Country) Massachusetts **Funeral** 1□M 20XF Months Days 83 011-01-4098 Director Usual Rasidance of Decedant death with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow. r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 200No Director Cecil Port Deposit Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 304 Rowland Drive 21904 Funeral permit. Pages 1 and 2 should be filed within 72 hours effer deat Department of Health and Mental Hygiene. Important: if flem 27 is merked other the any injury or other traumers. 12. Wes Decedant Evar In U,S. Armed Forces?, 1 ☐ Yes 2 ☑ No If Yas, Giva 11 Marital Statue 13. Wes Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14 Race - American Indian Biack, Whita, atc. 1 Nevar Married 2X Married 1 ☐ Yes 2 ☒ Xio Specify: ð 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12)
Twelve Years Collega (1-4or 5+) Homemaker Personal Residence 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) Frederick Upshall Margaret Shay 19a. Informant's Name/Raiationship (Type, Print) 19b. Malling Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) Allen F. Wells (Husband) 304 Rowland Drive, Port Deposit, Maryland 21904 20b. Place of Disposition (Nama of cemetery, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 In Cremetion 3 ☐ Ramovai from Stete R.A. Ferris & Co., Inc. 6/28/99 West Chester, Pennsylvania 4 ☐ Donation 5 ☐ Other (Spacify) 21. Signature of Funaral Sarvice Licer 22. Name end Address of Fecility Lee A. Patterson & Son Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 21903-0188 Approximata Interval Between Onset and Death **Physician** Dementia of Alzheimor's Type Coroboory Heart disease /Medical Immediata Causa (Finel disease or condition resulting in deeth) **Examiner** 425 physicien end s the burial-transit Sequantielly list conditions, if any, laading to Immadiata causa. Enter Underlying Cause (Diseasa or injury that initiated evants rasulting In daath) Last that the death certificate be axecu Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as e consequence of) d for use as t signed by the eld d be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Vasculitis 1 Yes 2 No 3 Probably 4 Onknown à 24b. Ware autopsy findings available prior to 24a. Was an autopsy parformed? Completed completion of cause of dasth? 1 Yas 2 No 1 ☐ Yes 2 ☐ No 25. Was case rafarred to medical Be 26. Place of Deeth (Check only one) axaminar? Othar: 4 Nursing Homa 5 Residence 8 Other (Specify) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Aftar 1 Neturel 5 Panding invastigation deeth. To the Hospital or Attendit within 24 hours after deeth.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yas 2 ☐ No 2 Accident 8 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar Medical 29d. Data signed (Month, Day, Year) 29b. Signatura apdytitla of certifiar 29c. Licanse number Sachder SMD 1)23322 6.26.99 30. Nama and eddrass of person who completed cause of deeth (Item 23a) (Type, Print) Suit 3B, Elkton MD 21921. 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State JUN 2 8 1999 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Dev Yeer **Physician** 21 Anita K. Wisniewski June 1999 7:20 A.M. /Medical 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hillcrest Drive Aberdeen
If Under 24 Hrs. Harford Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Deys Months Hours 10 M SENE Yrs 60 Director 195-30-7196 Oct. 25, 1938 Pennsylvania Usual Residence of Decedent the Maryland 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 TYPes 2 □ No Directo Maryland Harford Aberdeen 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 451 Hillcrest Drive 21001 U.S.A. Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Meritel Stetus filed within 72 hours after 1 Yes 2 No If Yes, Give Yeer or Dates: 1 ☐ Never Merried 2 ☑ Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: by 3 Widowed 4 Divorced White Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry alth and Mental Hygiene. 27 is marked other than 'r trsumatic event, tre Me Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker In home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) . Pages 1 and 2 should be fill ment of Health and Mental Hant: if Hem 27 is marked oth jury or other trsumatic even Be Anthony Bonk 0 Gertrude Butkiewicz 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 451 Hillcrest Drive, Aberdeen, Maryland 2100 Dete 20c. Location - City or Town, Stete Henry Wisniewski (Spouse) 20b. Place of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or once. Stanislaus P.N.C. 6/25/99 Scranton, PA 21. Signeture of Funeral Service Licansee 22. Neme end Address of Facility Tarring-Cargo Funeral Home, P. Aberdeen, Maryland 21001-3399 such es cardiac or respiratory arrest, Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Due to (or es e consequenca of): Examiner STINAL The law requires that the death certificate be executed -transit Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Last Due to (or es a consequence of): physician a Box 68760. Physician/Medical Due to (or es e consequença of) attending pl hed f Pert II. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. s been signed by the should be detache 2 No 3 Probably 4 Unknown 1 Yes p 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed s certificate has director, page 2 2 1 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: Be 25. Wes case referred to medical 26. Place of Deeth (Check aply one) examiner 1 Yes Other: 4 Nursing Home 10 1 | Inpatient 2 | ER/Outpetient 3 | DOA Pasidenca 6 Other (Specify) this funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Certification: 28b. Time of After Neturel 5 Pending investigation death. 1 ☐ Yes 2 No 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completaly filled in Medical 29e. Certifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. TENONG 29d. Dete signed (Month, Day, Year) 29c. License number 29b LUTHERVILLE MD. SUITE 230 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOAD CEMA, MD 10755 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar AUG 0 6 1999



			DEPARTMENT OF HEALTH AND ERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.	
		DAVID PERRY Young	r	2. DATE OF DEATH MONTH DAY DAY P	S. TIME OF DEATH
2		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. les	st birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.  MONTHS DAYS HOURS MIN.		BIRTHPLACE (State or Foreign Country)
2, 3 should	TOR	98. FACILITY NAME (If not institution, give street and number)  MCCREADY HOSP.  RESIDENCE OF DECEMENT	CR: SField		MCRSE T
t. Pages 1,	DIRECTOR	100. STATE 100. COUNTY SOMERSET	10c. CITY, TOWN OR LOCATION  RISTICALD		10d. INSIDE CITY LIMITS? 1 X YES 2 NO
nsit permit.	FUNERAL	100. STREET AND NUMBER 75 Somers COVE	10f. ZIP CODE		N OF WHAT COUNTRY?
215-0020 attending physician. se as the burial-transit	BY FUN	11. MARITAL STATUS  1 Never Married 2 Married  3 Widowed 4 Divorced  12. WAS DECEDENT EVER IN U.S. AF FORCES? 1 VES 2 IF YES, GIVE WAR OR DATES		in, Puerto Rican, etc.)	RACE — American Indian, Black, White, etc. Special Black
- × -	LETED	(Specify only highest grade completed) (G Elementary/Secondary (0-12) College (1-4 or 5 +)	ECEDENT'S USUAL OCCUPATION live kind of work done during most of working Do NOT use retired.)	16b. KIND OF BUSINESS/INDUS	
YLAND 2 by the hospital be detached to at once.	COMPL	17_EATHER'S NAME (First, Middle, Last)	OOD SERVICE	ME (First, Middle, Melden Surname)	soup Co.
MARYLAND 2. retained by the hospital of 5 should be detached for notified at once.	BE C	GARfield Young	LEN	A WARD	
2 5 0	10	Nicey Turpin - Niece P.	b. MAILING ADDRESS (Street and Number or Rural  O. Box 67 MARion	MD 218:	38
MORI ge 6 may irector, p			AND DATE OF DISPOSITION (Name of Imparty of other place)  TEER Ceme HERU	GATE 200 LOCATION - CH	
BALTIMORE, after death. Page 6 may be by the funeral director, page moval.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE  Sr.	22. NAME AND ADDRESS OF FA THOMY E. U 314 COUE ST.	Jaed tuncial Hor Ceisfield, MD	71817
lift 24 hours ely filled in la nation, or re , the med		23. PART t. Enter the diseases, or complications that caused the deahook, or heart failure. List only one cause on each line IMMEDIATE CAUSE (Finel disease or condition resulting in death)  S. MELOS Late	Squamous cell Co		Approximsta Interval Between Onset and Death
secuted and composition of burial.	NOIL	Sequentially list conditions, if any, leading to immediate			
	CERTIFICATION	CAUSE. (Disease or injury that initiated events  CAUSE (Disease or injury that initiated events	DUENCE OF):		
DS, P.O. Be the death certificate the attending physis is Mental Hygiene pri injury, or other the	CERT	resulting in death) LAST			
D S the c	EDICAL	PART II. Other significent conditions contributing to death but not r	esuiting in the underlying cause given in	Part I. 24a. WAS AN AUTOPSY PERFORMED?  1 YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
AL RECOR e law requires that has been signed by Dept. of Health an 23 shows any	Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEA	TH YES NO UNCERTAIL	N D	1 TES 2 NO
TA the ste h	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?  1 YES 2 NO 1 NO 1 NO NEDICAL: 1 No NEDICAL: 1 No NEDICAL: 1 No NEDICAL: 1 No NEDICAL: 1 No NEDICAL: 1 No NEDICAL: 1 No NEDICAL: 1 No NEDICAL: 1 NO NEDICAL	CE OF OEATH (Check only one)  OTHER:  DOA 4 Nursing Home 5 Residence	E Other (Specific)	
	ВУ РНУ	27. MANNER OF DEATH  15. Natural 5 Pending 2 Accident Investigation	28b. TIME OF 26c. INJURY AT WORK?  M 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCCUR	EO
ISIC ITENDI ITOR: A after de		3 Suicide 8 Could not be 4 Homicide 8 Could not be determined	me, tarm, street, factory, office	28t, LOCATION (Street and Number or City or Town, State)	Rural Route Number,
DIV TO THE HOSPITAL OR A TO THE FUNERAL DIREC be filed within 72 hours IMPORTANT: If Item	COMPLETED	29s. CERTIFIER (Check only one)  1 CERTIFYING PHYSICIAN: To the best of my knowledge, de medical examiner: On the basis of examination and/or in the basis o			euse(s) and menner as stated.
O THE H O THE R e filed wi	B	29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUM D 4800		GNED (Month, Dey, Year)
F F 5 *	2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITER BY VIJAY KAPUMBUNATUAN)	M 27) (Type, Print)	00.	111 31017
		31. DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	The state of the s	au Cristicid,	WD SIRI
		JUN 2 4 1999 Beneva G.	Spach		

FAVORED TO THE STATE OF THE STA AN THE STATE OF TH The man is the state of the sta A STATE OF THE STA 20 101 11 2 1 Application and the second of the second growth an egy ellon " more uno" the state of the second second second second second all me Het girite ja skerner fra 8 Acres 10 and 10 with a mineral plan with such a substitute MM. 

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2 Data of Death 3. Time of Death Month atherine ugustas 15 A.M 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Manor lice 5. Social Sacurity Number If Undar 1 Yaar | If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 6. Sax 1□ M 2X F Months Days Hours Min 218-18-3592 15 Yrs. Usual Rasidance of Dacedant 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Baltimore Ma 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 904 , S.A artmouth 21212 12. Was Decedant Evar In U,S. Armed Forcas? 1 ☐ Yas 2√2 No If Yas, Give/ Yaar or Datas: Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Navar Marriad 2 Married Specify: Black 1□Yes 2♥No 3 Widowad 4 □ Divorced 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Spacify only highast grada completed) 16b. Kind of Business/Industry Aberdem Proving Elementary/Secondary (0-12) Collaga (1-4or 5+) Grounds Worker 11th grade NA Factory 17. Fethar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Sumama) ardoza aru Winfield 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number of Rural Route Number, City or Town, Steta, Zip Coda) Barbara Dugger - Daughter 904 Dartmouth Road Balto, M4 21212 20b. Place of Disposition (Name of cematary, cramatory or othar placa) 20a. Method of Disposition

1. Burial 2 Cramation 3 Ramoval from Stata Data 20c. Location - City or Town, Stata Baltimore, md Natronal 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvige Licensas 22. Nama and Addrass of Facility ch F. H. West int. Entar the disease, or complications that caused the leath. Do not anter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List drily one cause on each line. 10a 140, rd 21215 Avenne Approximata Intarval Between Onset and Death fmmediata Causa (Final Sarcoidos 15 Pulmenar disaasa or condition rasulting in death) BUSTRUCTIVE PHIMOMETY disease Chronic Due to (or as a consequence of): Digbetic mellitus Dua to (or as a consaquance of): cerebral Vascular accident 23b. Dld tobacco usa contribute to the cause of death? 3 □ Probably 4 Unknown Cardiopulmonory arrest 1 Yes 2 No

**Physician** /Medical Examiner

signed by the et d be deteched fo

certificete

24 hours after death.

To the F within 2

funeral director,

n by

Be

Medical

Division of Vital Records,

or Attending Physician:

Hospital

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show na 23a or 28a-f show

permit. Peges 1 end 2 should be filled within 72 hours efter d Department of Health end Mentel hygiene. Important: If Item 27 Is marked other than "natural", or Item any Injury or other traumatic event, its Medical Examination

Baltimore, Maryland 21215-0020

Director

Completed by Funeral

Be

the Maryland

Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Ceuse (Diseese or Injury thet initiated avants rasulting in daath) Last Physician/Medical

Pert II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. þ 24b. Wara autopsy findings available prior to complation of cause of daeth? Completed 24a. Was an autopsy performad? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatlant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 ☐ Yas 2 No Certification: To 27. Menner of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 28e. Date of Injury (Month, Dey Year) Natural 5 Panding Investigation 1 Yas 2 No 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Pleca of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowladga, daath occurrad at tha tima, date and place, and dua to the cause(s) and mannar es steted. 29a. Certifian

Cartifying Physician: 10 the best of my knowledge, death occurred at the time, date and piece, and due to the dedect, and manual occurred at the time, date and piece, and due to the cause(s) and mannar stated.

29b. Signatura and titla of certifiar

29c, Licansa number

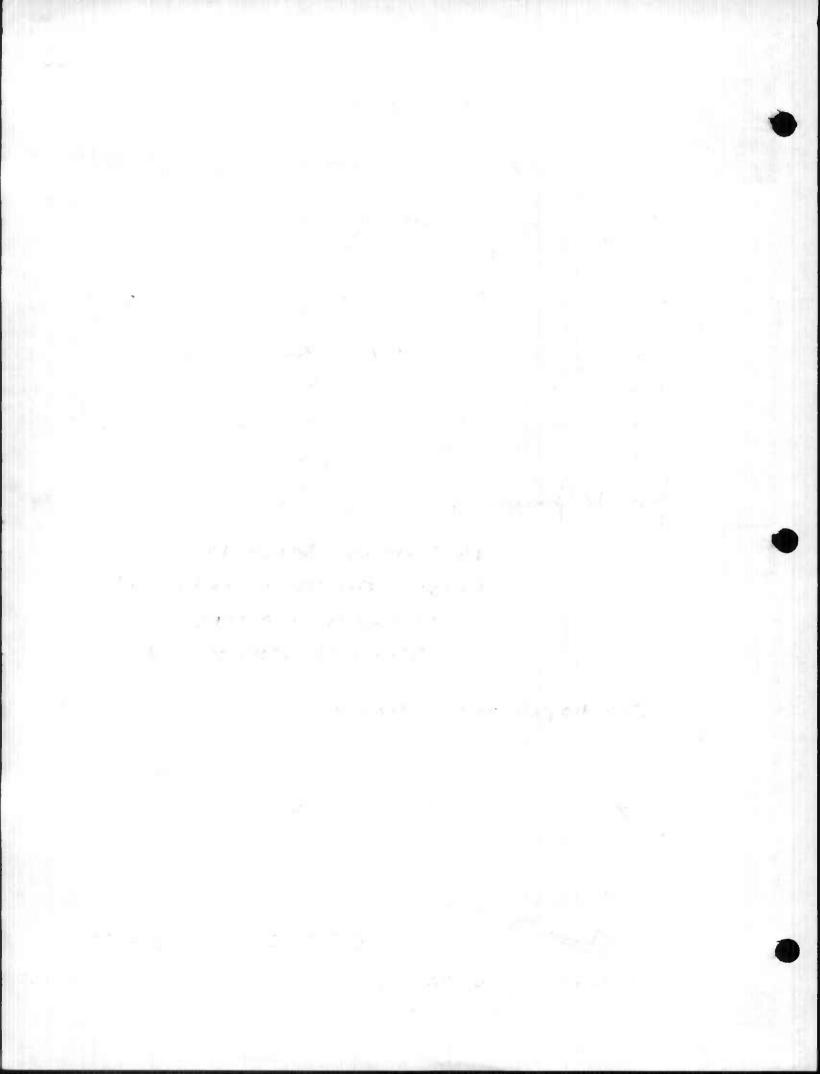
29d. Data signad (Month, Day, Yaar)

30. Nama and addrass of parson who complated cause of deeth (Item 23a) (Type, Print)

2600 Liberty HOT AVE Baltimore mo 21215 Ohlok Pehal, mo

State Registrar

31. Data filad (Month, Dey, Year) JUL 0 8 1999

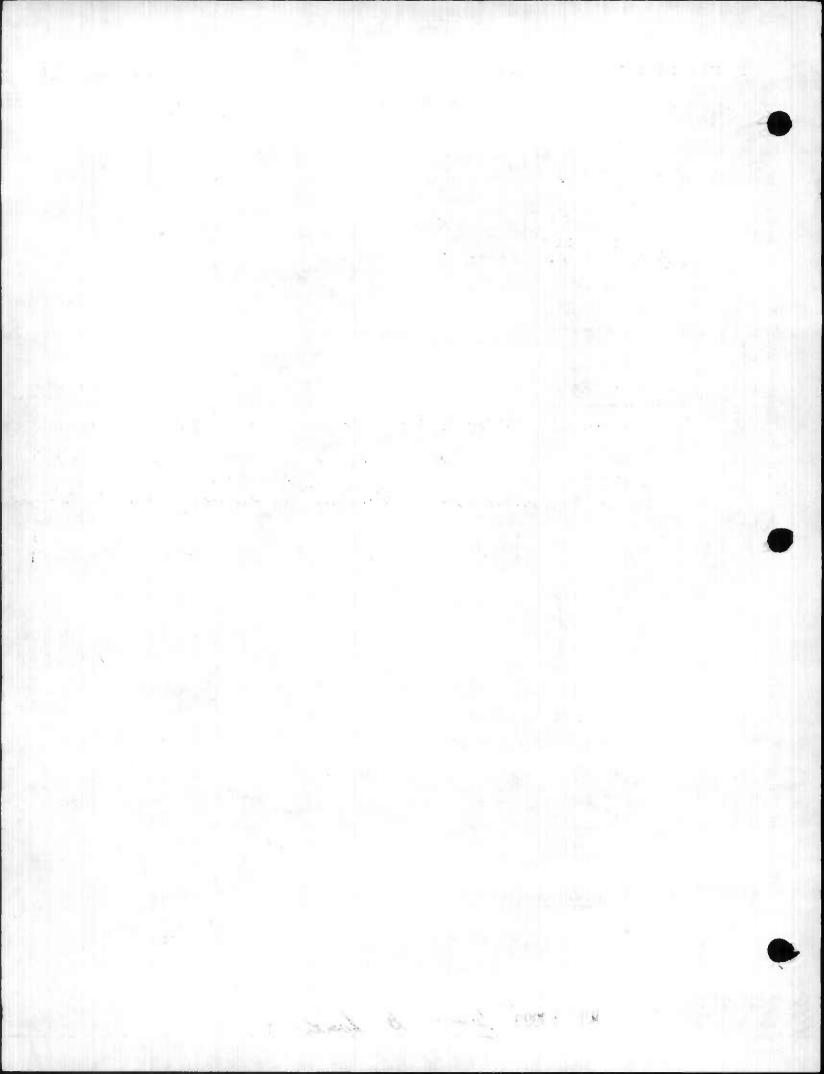


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/Medical	4a Facility Neme (If not Institution, give street and number	VICZAN	4b. City, Town, or Location of Dea	th 4c. County of Death
Examiner	HERITAGE NURSIA		NIA	BALTO.
Funerai		Age (In yrs. last birthday) If Under 1 Yes		irth 9. Birthplace (State or Foreign
Director	2/3.01.4758 10M 20F	Yrs. Months Day	Hours Min. (Month, D	ey, Year) Country)
2	Usuel Residence of Decedent			
Maryland f show	10a. Stete 10b. County	10c. City, Town or Location		10d. Inside City Limits
	MIS DALIO.	BAUTO.		
with the a or 28s or 28s or 28s	100. Street and Number AN HILL ROAD	10f, Zip Code	- 1	10g. Citizen of Whet Country?
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ter de	11. Marital Stetus  12. Wes Deceder Armed Force 1 Never Merried 2 Married 1 Yas 2	s? If Yes, specify Cu	f Hispanic Ongin? (Specify Yas or Nuban, Mexicen, Puerto Rican, etc.)	Bleck, White, etc.
020 urs at Mr. or		1 ☐ Yes 2 ☐ N	o Specify:	Specify: WHITE
1 21215-0020 led within 72 hours after yogiene. At the Medical Everties Completed by Fu	15. Decedent's Education	16a. Decedent's Usuat Occ	cupation ne during most of working	16b. Kind of Business/Industry
thin 7	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4c	tife. DO NOT use reti	red)	11
21 Sorth	8 0	Homen		Home
yiand 2 huld be filed Mental Hygin ricked other rick avent, I	17. Fether's Neme (First, Middle, Last)	1	18. Mother's Name (First, Middle	
yiar Neuta Menta mrked mrked	LAWRENCE LISE		MAGDALINE	KOSCIENIAK
Maryland d 2 should be file th and Mental Hy 7 is marked oth traumatic aven To Be	19a. Informant's Name/Relationship (Type, Print)		et end Number or Rural Route Num	1
CENL	MS. MARIAN HATE  20e. Method of Disposition	20b. Plece of Disposition (Name of	ICWORTH DR.	20c. Location - City or Town, Stata
TOT STORY	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Sta	cemetery, crematory or other p	olece)	1
altimore, mit. Pages 1 at partment of Hea portant: if item; y holury or othe Ea.	4 Donetion 5 Other (Specify)  21 Signature of Fundari Sarvice Licensee	ST. STANISLAN	15 17-7-99	BALIO, IVID.
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	23a Part 1 Enter the disease or a validations that cause		NDAZK AZENU	
Physician	23a. Pert1. Enter the disease, or or or plications that caus shock, or heart failure. List only one cause on each	line.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Interval Between Onset end Death
/Medical	Immediate Cause (Final	nessia la	T Riz	earl up.
Examiner	disease or condition resulting in death)	Due to (or as e consequence of):	4, ,	Jeas
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executed and isl-transit	Sequentially list conditions,	Due to (or as e consequence of):		
	Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.			
V . 60 0	that initiated events	Due to (or as e consequence of):		
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0 > 0 %	Jack ms	C. Frazz	pai	completion of cause of death?
The la rate has page Com	Dergueners	Jost Riz	erl 10	Yes 2010 1 Yes 20 No
f Vital Recognitions to be set of the law director, page 2	25. Was case referred to medical examiner?		26. Place of Death (Check only	one)
- 5 % D	1 Yes 2 Inpe	itient 2LI ER/Outpatient 3LI DOA		sidence 6 Other (Specify)
Division of or Attending Physical Cost.  Journal of the Street of the Street of the Street of St	27. Mennand Death 1 Planting 5 Pending (Month, i		Vork?	e how Injury occurred
Attending or death.  actor: After fune fune fune fune fune fune	2 Accident investigation 3 Suicide 6 Could not be		Yes 2 No	(S)
or Att	ristamminari 200. Flace oi	Injury - At home, ferm, street, factory, office etc. (Specify)		(Street and Number or Rural Route Number, own, State)
De la la la la la la la la la la la la la	29a, Certifier 12 Certifying Physician: To the be-	at of my knowledge, death accurred at the	time date and place and due to the	
Division of the Heaptal or Attending Privation 24 hours state death. To the Funeral Director: Affect this completely filled in by the funeral Medical Certification:		st of my knowledge, death occurred et the of examinetion end/or investigation, in most stated.		e cause(s) end menner es stated.  e, date end piace, and due to the cause(s)
o the vithin o the comple	29b. Signature and title of certifier		anse number	29d. Date signed (Month, Dey, Year)
- SFO	· Munici	D	28350	7/3/99
1	30. Name and eddress of person who completed cause of	f death (Item 23a) (Type, Print)	3 < ( . 1 . 1	MTOMST
	GRACIAY PSTR	icio DI	Ct 1 France	16001 2/22 X
State	31. Dete filed (Month, Day, Year). 32. Regi	strar's Signature		
Registrar	JUL 8 1999	eners & 1.		

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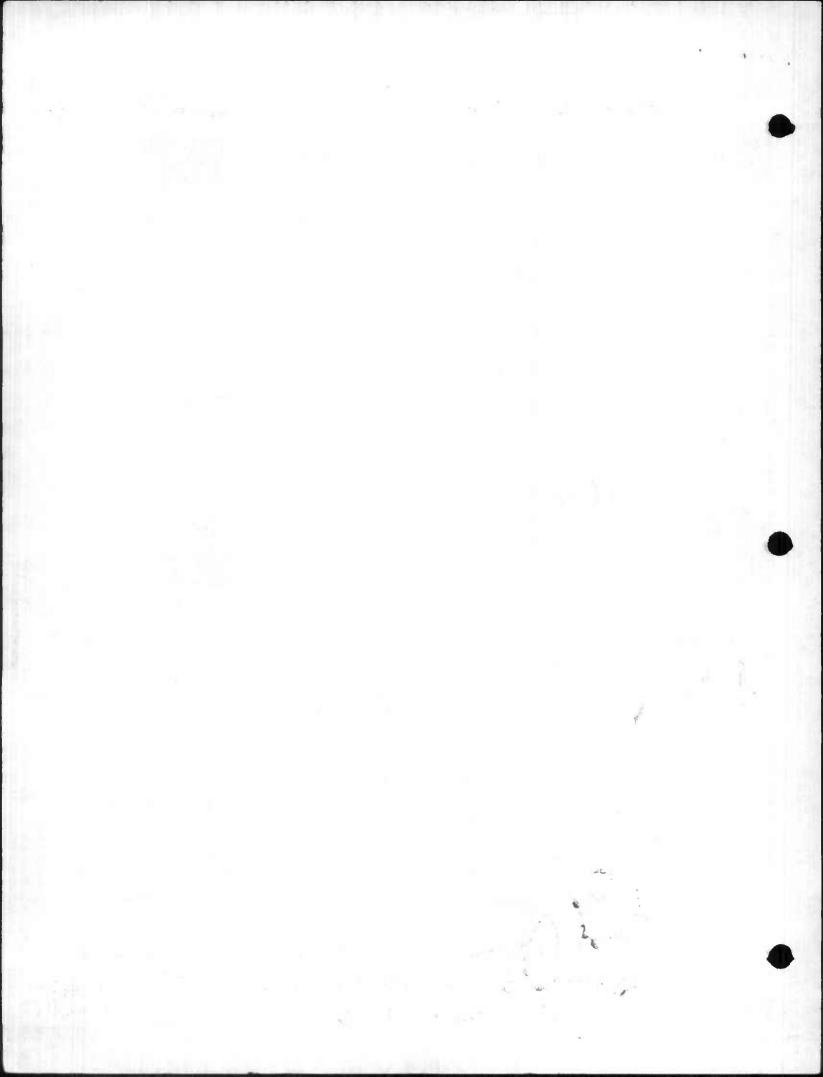
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## Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q. C.

State of Maryland / Department of Health an Certificate of Death	nd Mental Hygiene 9 9 2   4 2 5
Physician  1. Decedent's Name (First, Middle, Last)  Physician  ARIOL A BV 511	2. Date of Death Nonth Day Yaar
//wedical	or Location of Death 4c. County of Death
	er Spring Montgomery
Funeral Director  5. Social Security Number 6. Sex 1 Morths 1 M 2 M F 72 Yrs.  6. Sex 7. Age (In yrs. lest birthdey) 72 Yrs.  7. Age (In yrs. lest birthdey) Morths Days Hours 1 Morths Days 1 Morths Days 1 Morths Days Hours 1 Morths Days 1 Morth	8. Data of Birth Min. (Month, Dey, Year) June 10, 1927  9. Birthplaca (Stete or Foreign Country) Wisconsin
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
10a. State 10b. County 10c. City, Town or Location  MD Montgomery Silver Spring  10a. Street and Number 10b. Zip Code	1 □ Yes ¾DXNo
10e. Street and Number	10g. Citizen of What Country?
8750 Georgia Avenue #518 A 20910  11. Marital Status  12. Was Decedant Evar In U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 1 Yes, specify Cuban, Mexicen, P	USA (7 (Specify Yes or No-
3 □ Widowed 4 Divorced   If Yes, Give   1 □ Yas 2 No Specify:	Puarto Ricen, etc.)  Black, White, etc.  Specify: White
Second   S	f working 16b. Kind of Business/Industry
Elementary/Secondery (0-12) College (1-4or 5+) 12 2 Medical Transcribing	
To the state of th	Name (First, Middle, Meiden Sumema)
Charles L. Foote  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of Street jorie E. Searles	
Charles L. Foote  Mar  19a. Informant's Name/Relationship (Type, Print)  Robert Grimwood/Friend  8750 Georgia Avenue	or Rural Route Number, City or Town, Stete, Zip Code) 518-A, Silver Spring, MD 20910
	Date 20c. Location - City or Town, Stata
1 Burial 2 Cremation 3 Ramoval from State 4 Donation 5 Dotter (Specify)  1 Baltimore Washington Cr	c. 6/24/99 Laurel, Maryland
20a. Method of Disposition (Nema of cemetery, cremetory or other place)  1 Burial 22 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify)  21. Synaturally Fundation 5 Removal from State  22. Nama and Addrass of Facility Fleck Funeral Ho	ome, Inc.
Physician /Medical Examiner  Physician /Medical Examiner  Physician /Medical Examiner  Physician /Medical Description  Immediate Cause (Final disease or condition resulting in death)  Due to (or es a consequence of):	
b. Due to (or as a consequence of):	
d.  Part II. Other eignificant conditions contributing to death but not resulting in the undarlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?
O. 4 the definition of the state of the stat	1 Yes 2 No 3 Probably 4 Unknown
0 5 9 0 Q	24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?
	1 ☐ Yes 2 ☐ No 1 ☐ Yas 2 ☐ No
25. Was case referred to medical examiner?  1   Yes   2   No	Deeth (Check only one)
Hospital: 1   Inpatient 2   EP/Outpatient 3   DOA   Other: 4   Nursing the control of the contro	ng Home 5 Pasidence 8 Other (Specify)  28d. Describe how injury occurred
27. Manner of Death 1 Dry Natural 2   Accident 3   Suicide 4   Homicide 28e. Date of Injury 28b. Time of Injury 28b. Time of Injury at Work? 1   Yes 2   No 28c. Injury at Work? 1   Yes 2   No 28c. Injury at Work? 28c. Date of Injury 4   Homicide 28c. Date of Injury 4   Specific   Speci	28f. Location (Street end Number or Rural Route Number, City or Town, Stete)
	lace, and due to the course(s) and manner as stated
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifiar  29c. Licanse number	occurred at the time, date and place, and dua to the cause(s)  29d. Date signed (Month, Dey, Year)
and manner stated.	occurred at the time, date and place, and dua to the cause(s)
29a. Certifier (Check only one)  29b. Signature and title of ovriffiar  29b. Signature and title of ovriffiar  29c. Licanse number  30. Name analydoress of parson who completed cause of death (Item 23a) (Type, Print)	occurred at the time, date and place, and dua to the cause(s)

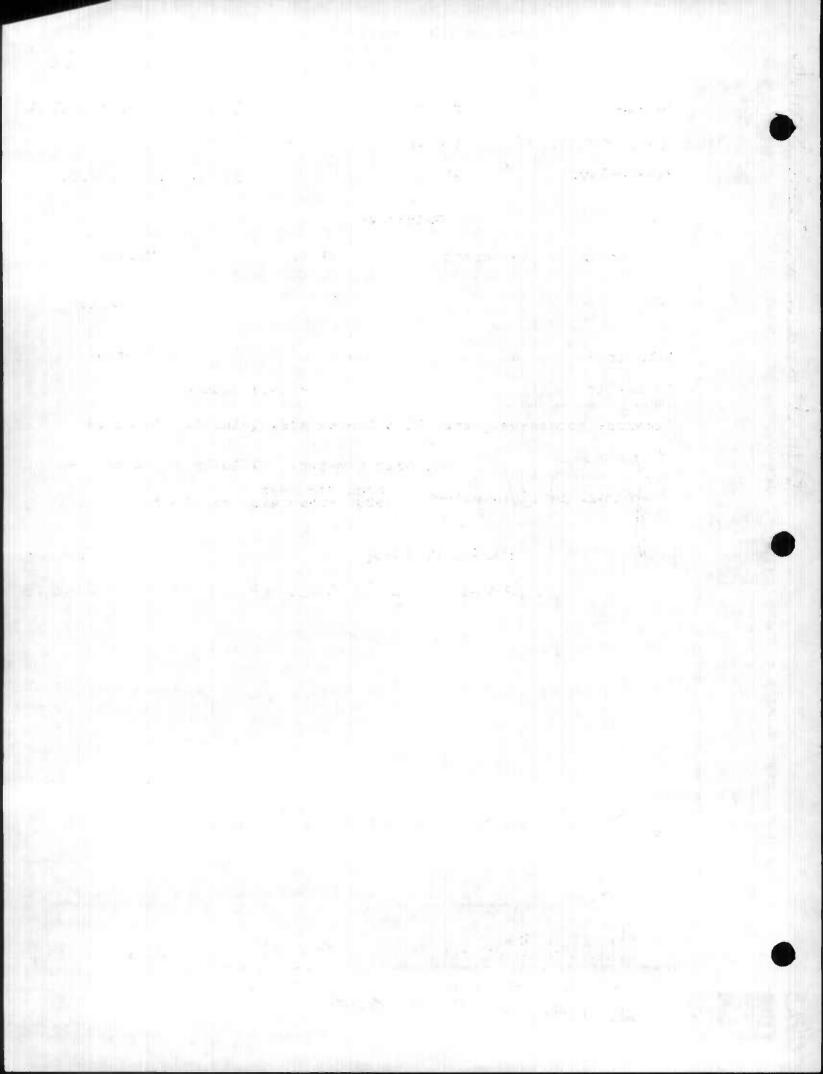
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene essie Brandon Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Yeer Physician Jessie 1999 Brandon JULY 4:50 AM 0 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner BALTIMORE 5. Social Security Number HOSPITAL OF BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Deys 1□M 21XF 217-26-1900 Director 24 08 N.C. Usual Residence of Decedent 10a. Stete 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 □ No Director Baltimore 28a-f MD NA 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? must be r 2220 North Monroe Street 21217 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) the Medical Examiner my 12. Wes Decedent Ever In U,S. Armed Forces? 14. Race - American Indien, 11. Maritel Status Black, White, etc. 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: by 3 Widowed 4 ☐ Divorcad KNOWN Yeer or Dates: Black Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Cook Restaurant 10th grade na 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Sallie Johnson Ed Lester 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. informent's Neme/Reletionship (Type, Print) Bam 27 3326 Elmley Ave. Baltimore Md 21213 Eleanora Morgan-Daughter 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, State 6 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Dorpation 5 ☐ Other (Specify) Mt. Zion Cemetery

22. Name end Address of Fecility 7/10/99 Baltimore, Md 21. Signature of Funerel Service/Ormsee March F/H West 4300 Wabash Ave, Baltimore Md 21215 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Couse (Final disease or condition resulting in deeth) /Medical PNEUMONIA Examiner RENAL CELL CARCINOMA Examin certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest Due to (or as a consequence of) physician a s the buriel-Box 68760. Physician/Medical Due to (or es e consequence of): 88 98 23b. Did tobacco use contribute to the cause of death? P.0. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Records, þ Sign 1 De 24b. Were autopsy findings eveileble prior to 24a. Wes en eutopsy Completed completion of cause of death? is certificate has director, page 2 1 □ Yes No Division of Vital 25. Wes case referred to medical examiner? Be 26. Piace of Deeth (Check only one) Hospital: Inpatient To 1 Yes 2 No Other; 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 1 2 Naturel 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred Certification: 28c. Injury et Work? After Attending 5 Pending Investigation s after dec. 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) end menner es steled.

2 Medical Examiner: On the best of examination end/or investigation, in my opinion, deeth occurred at the time, dete end plece, and due to the cause(s) end menner steled. edicai 29e. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number MD 13214 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) 2401 W. BELVEDERE AVE CHRIS HA, SINAI HOSPITAL OF BALTIMORE, BALTIMORE, MD 21215 2. Registrar's Signature 31. Dete filed (Month, Dey, Year) State JUL 0 8 1999 Registrar



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** Olive Virginia Billings 4b. City, Town, or Location of Death /Medical 1999 5:05 AM 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth **Examiner** Ivy Hall Geriatric Center Middle River Baltimore Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 15, 1919 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 ☐ M 2 1 F 230 01 3636 80 Director Virginia Usual Rasidance of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow r than "natural", or items 23s or 28s-f show 1 Yas 2 No Directo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 223 Orville Road 21221 USA 11. Marital Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Raca - American Indian, o filed within 72 hours efter de il Hygiene. Bleck, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Peges 1 and 2 should be fill ment of Heelth and Mental Hant: If Item 27 la marked oth lury or other traumatic even Be William W. Sandy Olive L. White 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Edgar Billings (husband) 223 Orville Road Essex, Maryland 21221 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burlel 2 ☐ Cremation 3 ☐ Removet from State Department of important: If any injury or Holly Hill Mem. Gardens 7/10/1999 Balto. County Maryland 4 ☐ Donetion 5 ☐ Other (Specify) Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 aused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate Interval Between Onset and Death Physician /Medical immediate Cause (Fine) nemma disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Physician/Medical Examiner ician and burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) accident Cercon vascula Box 68760, Due to (or as a consequence of): Diabetes P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Mseare 1 Yes 2 No 3 Probably 4 Unknown Varn Records, þ 24b. Were autopsy findings available prior to completion of cause ot death? Completed 24e. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medical Certification: To 1 ☐ Yes 2 € No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 1 Natural 28b. Time of tnjury 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending investigation Division death. 1 Yas 2 No 2 Accident s after death 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 ☐ Could not be 3 Suicida 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D31464 ama 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Dr. Shoib A. Hashmi 821 N. Eutaw Street Suite 308 Baltimore Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 1999 Registra

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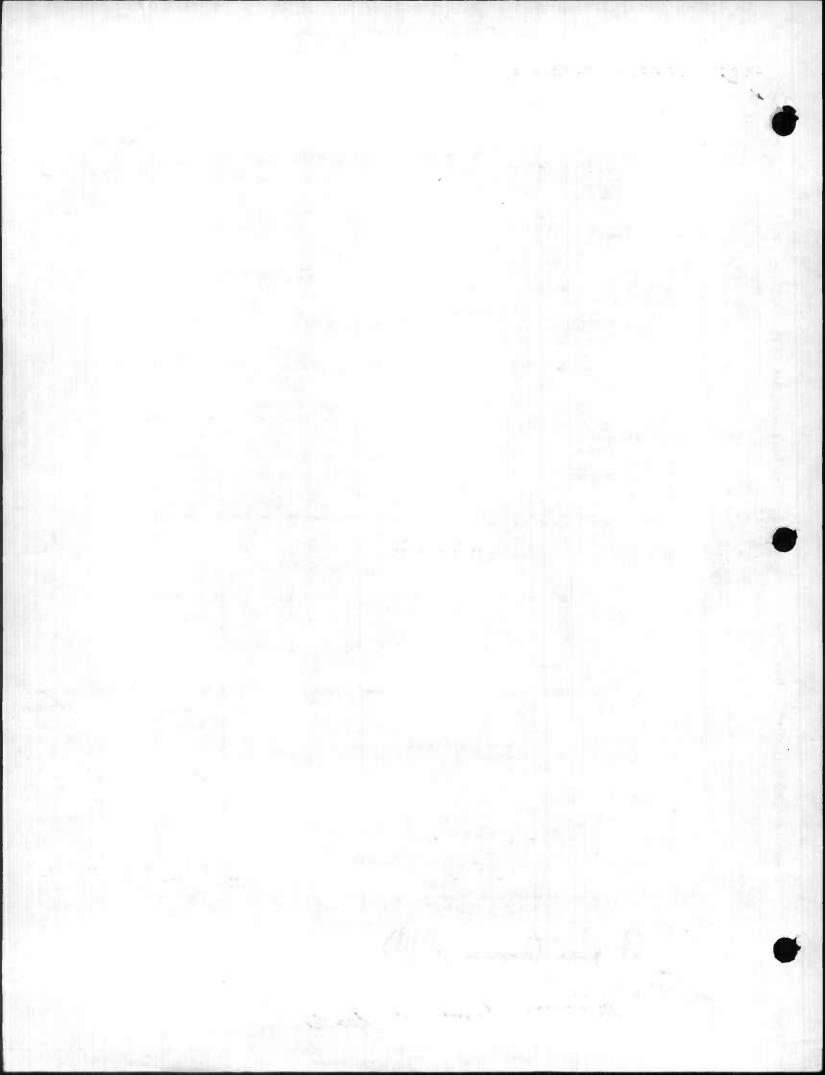
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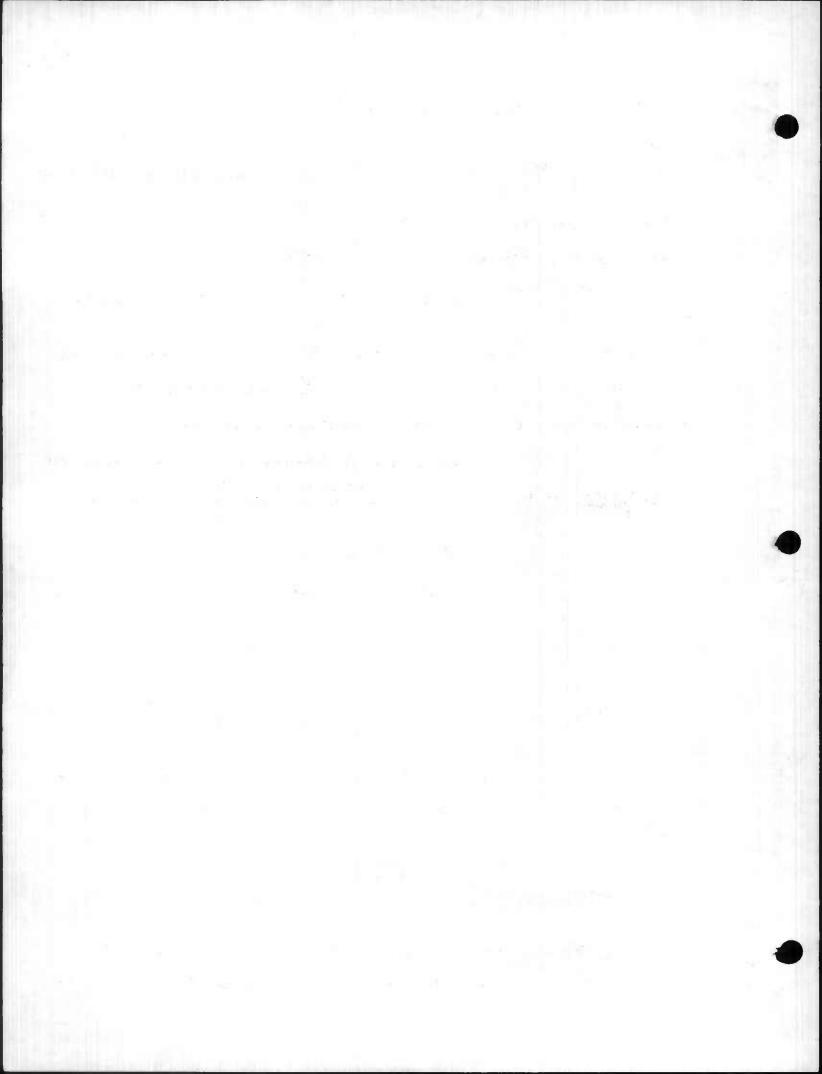
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	Examiner	4a Facility Name (If not institution, give 2610 EAST HOFFMAN			4b. City, Town, or Los BALTIMORE		County of Death	2		
	Funeral Director	220 10 7600	7. Age (In yrs. last		fear If Under 24 Hrs. lays Hours Min.	8. Date of Birth (Month, Day, Year) Aug. 29/		place (State or Foreign ntry)		
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altimore, Maryland 21215-0020  mit. Pages 1 and 2 should be filed within 72 hours after death a partment of Health and Mental Hyglene.  portant: If then 27 is marked other than "natural" or thams 234 piqury or other traumatic event, the Medical Examiner must as.  To Be Completed by Funeral	11. Merital Status  1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces?  1 ☐ Yes 25 No If Yes, Give Year or Dates:	13. Was Decedent If Yes, specify	t of Hispanic Origin? (Spe Cuban, Mexican, Puerto I						
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State of Maryland / Department of Health and Mental Hygiene o o

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7 is marked other than "natural", or frems 23s or 28s-f show traumatic event, the Modical Exercise must be notified as

**Physician** 

/Medical

Examiner

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Director

Funeral

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiena, moortant; if flow 27 is marked other than

Baltimore, Maryland 21215-0020

Physician /Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completally filled in by the transit director, page 2 should be detached for use as the buriar-transit Division of Vital Records, P.O. Box 68760, Medical Certif

etec	15. Decedent's l		168	Decedent's Usual ( (Give kind of work	done during most of wo	16b. Kind of Business/Industry  Janitorial				
Completed	Elementary/Secondary (0-12) Unknown	College (1-4or 5		Westic W						
17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Unavailable Lula Cooley										
-	19a. Informant's Neme/Relationship	(Type, Print)	19	b. Mailing Address (S	Street and Number or R		er, City or Town,	State, Zip Code)		
	Barbara Smith									
	20e, Method of Disposition		20h Piace (	4004 Lynd of Disposition (Name		, Baltim Date	ore, Mar	cyland 21217 City or Town, State		
	1 Burial 2 Cremation 3		camete	ery, crematory or other	er place)			Laurel, Maryland		
	21. Sgnatunga Fungal Sento tro	7	µIIIacon	22. Name and	Address of Facility Funeral Ho			Maryranu		
(	23a Jana Enha of disease, or consultation of the consultation of t	y one ceuse on each lin	10.				Laurel,	Maryland 20707 Approximate Intervel Between Onset and Death		
Physician/Medicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury fhat initieled events resulting in death) Last	c. <u>Cen</u>	Due to (or as a	consequence of):  consequence of):  vas cular  consequence of):						
	Part ff. Other significant conditions	contributing to death bu	of not resulting	in the underlying cau	se given In Part I.			ntribute to the cause of death?		
Completed by							s an autopsy ormed?	24b. Were autopsy findings available prior to completion of cause of death?		
Con						10	Yes 2 No	1 Yes 2 No		
10 86	25. Was case referred to medical exeminer?	Hospitei: 1 Inpatie	nt 2 🗆 ER/O	utpetient 3 DOA	Other:	eth (Check only	on <i>e)</i> idence 8 □Oth	er (Specify)		
tification: T	27. Manner of Deeth  1 Netural 5 Pending 2 Accident investigation	28a. Dete of Injur (Month, Day	y 28b.		: Injury et Work? 1 Yes 2 No		how injury occur			
titic	3 Suicide 6 Could not determine		iry - At home, f	arm, street, factory, o	office	28f. Location (Street end Number or Rural Route Number, City or Town, State)				

State Registrar 29a. Certifier (Check only one)

29b. Signature and fitle of certifie

DHMH 16 Rev 6/95

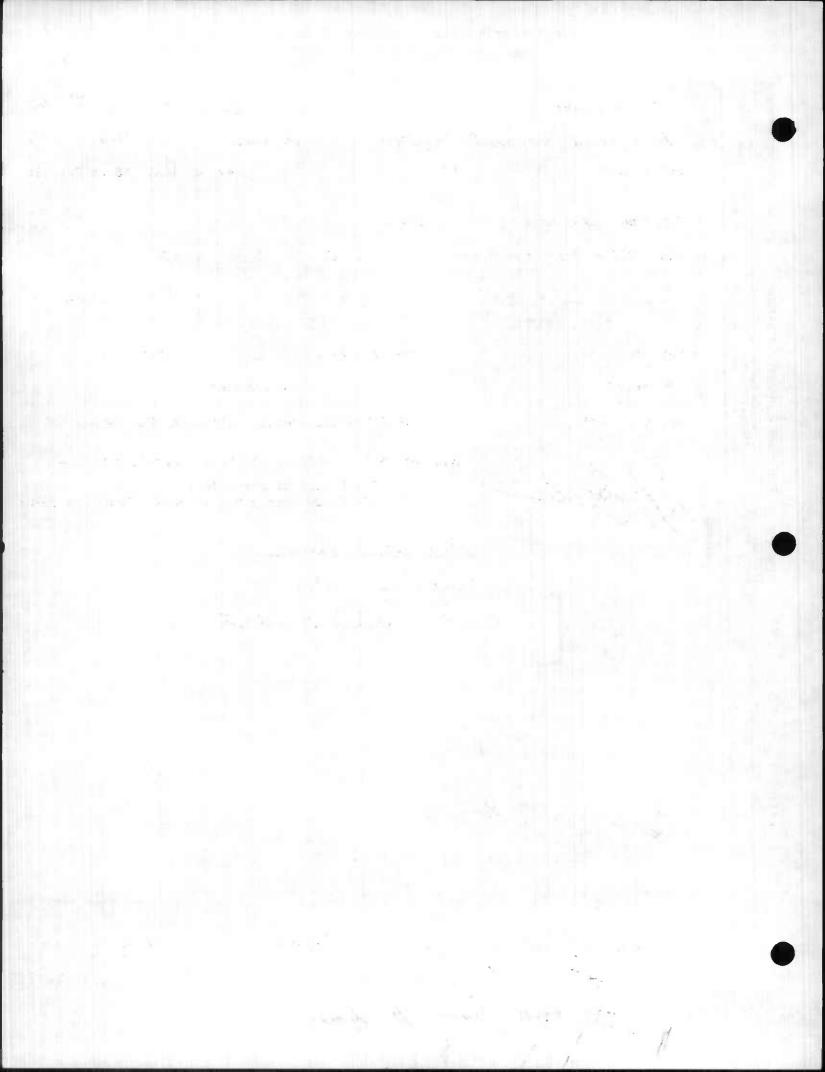
30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Hospital Drive, cherely, Maryland 20785

1 \_\_certifying Physician: To the best of my knowledge, death occurred at the time, date and piaca, and due to the ceuse(s) and manner as steted. 2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

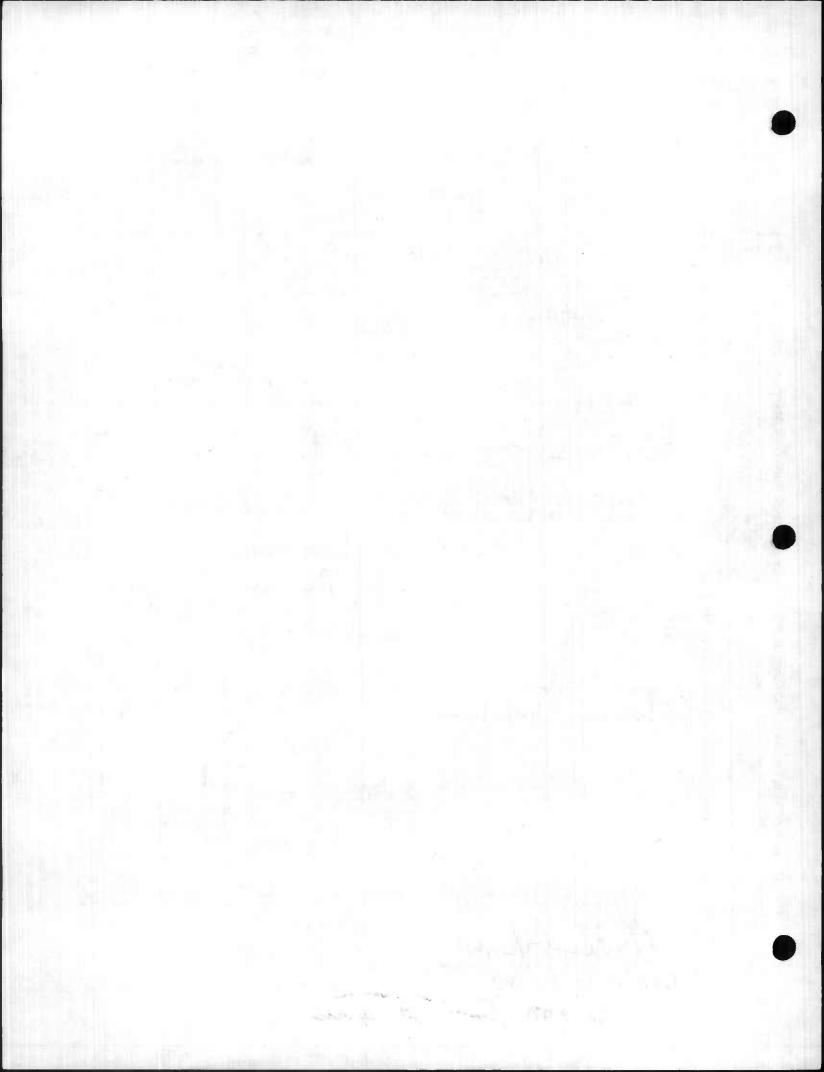
29d. Date signed (Month, Dey, Year)



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State of Maryland / Department of Health and Mental Hygiene 9 2 | 4 3 |

			Ce	rtificate o	t Death	Reg	g. No.	from 1 TY	0 1
Physician	1. Decedent's Name (First, Middle, La Charles B	2. Date of Death Month	Death Day Year		Tima of Death				
/Medical						July 0	4, 199		42 A.M.
Examiner	4a Facility Name (If not institution, giv				4b. City, Town, or Lo		4c. County	of Death	
	4806 Lorelly Aver		nt 4B yrs. last birthday)	If Under 1 Yes	Baltimore		N/		Cana Fi
Funeral Director		XX 2□F 51	Yrs. Wast Distributy	Months Day		8. Date of Birth (Month, Day, 1	Year) 48	Country) NC	State or Foreign
ð u	10a. State 10b. County	100	City, Town or Lo	ocation				10d. In	side City Limits
28a-f ahow notified at	MD NA		Baltimo	ore				*	XYas 2□No
recto	10e. Street and Number			10f. Zip Code	)	109	g. Citizen of V	Vhat Country?	
0	4806 Lorelly	Avenue A	pt.4B	2120	6		USA		
Funeral Director	11. Marital Status	12. Was Decedent Ever i	in U,S. 13.	Was Decedent o	Hispanic Origin? (Speuban, Mexican, Puerto	cify Yes or No-		e - American Inc k. White, etc.	dian,
by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Specify:			Specify		
P	15. Decedent's Ec (Specify only highest gra	ducation	16a. Dece	dent's Usual Occ	supation	10	6b. Kind of Bu	usiness/Industry	
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			ne during most of worki ired)				
S	11th Grade	NA	Labo	orer	1			us tra	des
B	17. Father's Name (First, Middle, Last)				18. Mother's Name			16)	
2	Marvin G. C				Rebecca		orne		. 01015
	19a. Informant's Name/Relationship (				elvedere				
	Jerry Clanto 20a. Method of Disposition		b. Place of Dispo	osition (Name of				City or Town, S	
	1 XBurial 2 Cremation 3	Bonney Trop State	cemetery, cre	matory or other p	Cemetery				
	21 Signature of Funeral Service Licer								
8008	· Idenia 14	a also			dress of Facility Balanch FH 1.				
	21s Fart1 Enter the disease, or com- shock, or heart failure. List only	plications thet caused the cone cause on each line.	leath. Do not en	ter the mode of d	lying, such as cerdiac o	r respiratory arres	st,	Inter	oximate val Between
ian		11	A.	1 1				Onse	et end Deeth
eal ner	Immediate Cause (Final disease or condition resulting in death)	Hyper	Fersil	re Mes	Discore	VC.			
	resulting in dealth)	Due	o (or as a conse	quence of):	Λ			1	
dical Examine		x (00	Worser	sler	Pisease			1	
Examiner	Sequentially list conditions, if any, leading to immediate	Due t	o (or as a conse	quence of):					
	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	c							
edical	that initiated events resulting in death) Last	Due to	o (or as e consec	quence of):					
an/M		d		14 4				1	
Physician/	Part It. Other significant conditions of	ontributing to death but not	resulting in the u	inderlying ceuse	given in Part I.	23b. Did tob	acco use cor	ntribute to the	cause of death?
F	Chimaniz 1	Machalian				1 ☐ Yes	8 2□ No	3 Probably	4 Unknown
by								A	dament die di
Completed by Physician/						24a. Was en performe	autopsy ed?	available	topsy findings prior to ion of cause
Idu								of death	7
						1 Yes	2 □ No	Yes	2 No
B	25. Was case referred to medical axaminer?	Hospital:		1.	26. Place of Death	(Check only one	)		
To Be	15 Yes 2 No	1 LI Inpatient	2 ER/Outpatie	NE SLI DUA		me 5 Residen			
On	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Yea	28b. Time o	V	lork? □ Yes 2 □ No	28d. Describe how	v injury occur	ed .	
	2 Accident investigation		At home form of			28f. Location (Stre	and Alumb	er or Rural Rou	In Number
cat	3 Suicide 8 Could not be	28e. Place of Injury - / building, etc. (Sp	u nome, tem, st ecity)	reet, ractory, offic	78	City or Town,		or Mural Mou	ie rvuriber,
ertificat	3 Suicide 8 Could not be determined				time date and place	and due to the ac-	sea(s) and ma	innar se stated	
i Certification:	4 Homicide determined	veloien: To the best of co-	knowledge de-4		time, uate and place, a				
dical Certificat	4 Homicide determined  29a. Certifier 1 Certifying Ph	ysician: To the best of my niner: On the basis of exam and manner stated.			y opinion, death occurre	ed at the time, dat	e and place,	2110 000 10 010 0	cause(s)
Medical Certificat	4 Homicide determined  29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	niner: On the basis of exam		vestigation, in m	y opinion, death occurre			d (Month, Day,	
edical	4 Homicide determined  29a. Certifier (Check only one)  1 Certifying Ph. 2 Medical Exam	niner: On the basis of exam		vestigation, in m	ense number	290	d. Date signe	d (Month, Day,	
edical	4 Homicide determined  29a. Certifier (Check only one)  29b. Signature and title of certifier	inher: On the basis of exame and manner stated.	nination and/or in	29c. Lice		290		d (Month, Day,	
Medical Certificat	4 Homicide determined  29a. Certifier (Check only one)  29b. Signature and title of certifier	niner: On the basis of exam	ination and/or in	29c. Lice O.C Print)	onse number	290 J	d. Date signed	d (Month, Day,	Year)
plataly fill edical	4 Homicide determined  29a. Certifier (Check only one)  29b. Signature and title of certifier	inher: On the basis of exame and manner stated.	ination and/or in	29c. Lice O.C Print)	ense number	290 J	d. Date signed	d (Month, Day,	Year)

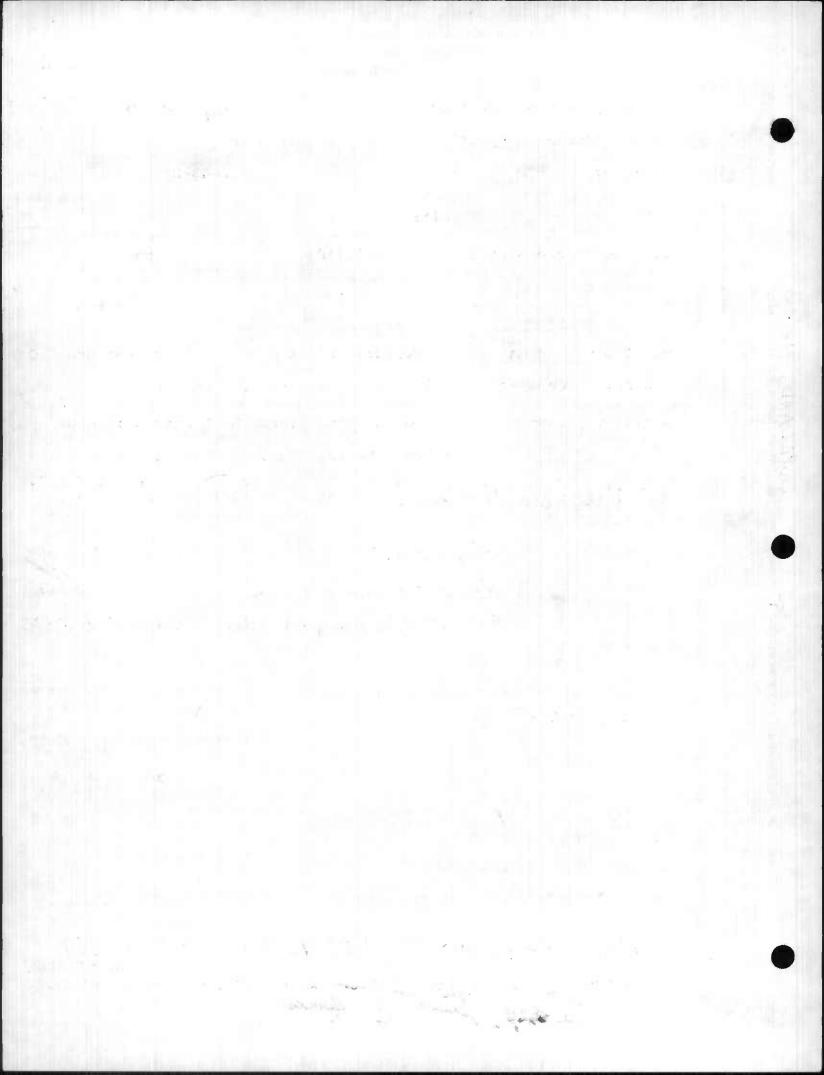


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State of Maryland / Department of Health and Mental Hygiene

	Certificate of Deat	th	Reg. No.	99 2	1432				
Dhualaian	Decedant's Name (First, Middla, Last)	2. Data Mor	a of Daath	/ Yaar	3. Time of Death				
Physician /Medical	Henry Jerome Copeland	Ju	4 04		02:15 AM				
Examiner		, Town, or Location o	f Death 4c.	County of Death					
		ltimore	15:45	NA					
rector	5. Societ Security Number  231-12-5723  6. Sex 1 M 2 F 75  7. Aga (In yrs. last birthday) 75  Wonths Days Hour  Usual Rasidance of Decedant	irs Min. (Moi	of Birth hth, Day, Year) -03-23	9. Birth Coo	nptaca (State or Foraign intry) D				
ě m	10a. Stata 10b. County 10c. City, Town or Location	-			10d. Insida City Limits				
De notified at Director	MD NA Baltimore				Yas 2□ No				
be notified Director	10e. Street and Number 10f. Zip Code	10g. Citi	izan of What Cou	untry?					
rai	1764 Homestead Street 21218			USA					
Funeral	11. Maritel Stetus  12. Wes Decedent Evar In U,S. Armed Forcas?  13. Was Decedant of Hispenic If Yas, specify Cuben, Mexi	: Orlgin? (Specify Ye: kican, Puarto Rican, e	s or No-	<ol> <li>Race - Amar Black, White</li> </ol>					
by F	1 Nevar Married	city:	100	Specify: B1	ack				
	15 Decedent's Education 16a Decedent's Lisual Occupation	16a. Decedent's Usual Occupation							
e a a a	Elemantary/Secondary (0-12) Collaga (1-4or 5+)								
	6th Grade NA Sparrows Point		Bethlehem Steel Co						
		ary J.	Edwar						
2	19a. Informant's Name/Ratationship (Type, Print)  19b. Mailing Addrass (Straat and Nut	•			ip Code) 21212				
T IVE	Doris Copeland 607 Winston Av								
other	20e. Mathod of Disposition 20b. Place of Disposition (Nama of	Data		ocation - City or					
ير م	1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify)  Arbutus Mem. Pk. C	Cem. 07-	09-99	Arbutu	s ,MD				
any injury poce.	21. Signatura of Funaral Sarvica Licensaa Holland WM.C. March	Balt			and 21202				
	23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such shock, or haart failure. List only one cause on aach tina.			0101111	Approximate Intervat Between				
cian	Shock, or haan failure. List only one cause on each that.				Onsat and Death				
lical iner	Immediate Cause (Final diseasa or condition				6 weeks				
	Due to (or as a consequence of):			1					
nie -	b. Respiratory faile	me			1 month				
by Physician/Medical Examiner									
Sicio	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	art I. 23	b. Did tobacco	uae contribute	to the cause of death?				
Phys	PE, Ashestonio		1 Yes 2	.□ No 3□ Pr	obably 4 Unknown				
by by	1 - 1 Amuscomo		,		Africa - Arra -				
ector, page 2 should be de Be Completed by P		24	a. Was an autoperformed?		Nare autopsy findings available prior to completion of cause of death?				
Page			1 ☐ Yas 2	No 1	I □ Yas 2 No				
Be (	axaminer?	Place of Death (Chec	k only ona)						
dire	1 ☐ Yes 200 No Hospital: 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐	Nursing Homa 5			city)				
ion:	27. Manner of Death  1 Natural 5 Panding (Month, Day Year)  1 Natural investigation  1 Natural investigation    Natural   1   1   28c. Injury at Work?   28c. Injury at Work?   1   28c. Injury at Work?   1   28c. Injury at Work?   1   28c. Injury at Work?		scribe how inju	ry occurred					
y the	3 Suicida 6 Could not be	28f. Loc	ation (Straat ar	nd Number or Ru	ıral Routa Number,				
erti	4 Homicida datamined building, atc. (Specify)	City	or Town, State	a)					
completely filled in by the funeral director, page 2 should be deteched for use  Medical Certification: To Be Completed by Physician/	29a. Certifiar (Check only one)  1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data 2 Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, and mannar stated.								
To the Funeral Director: After completely filled in by the funer completely filled in by the funeral Medical Certification:	29b. Signature end title of cartifiar 29c, License numb			ta signad (Monti					
1)	Chun Hone, MD AT 243	38946	Jul	44,1	999				
	30. Name and address of person who completed causa of death (Itam 23a) (Type, Print)  Chun Hono, M.D. Ilnian Memoral t	Hospital	201E	. Unive	999 rsity PKWY MD 21218				
State	31. Data tiled (Month, Day, Yegr) 32. Registrar's Signature		emi!	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	TIN AIMO				
Registrar	JUL 81999) Sime 15. papace.								

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Craven 1999 Virgi July 1710 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Hospital Regional Prince George's Laure Laure 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year ff Under 24 Hrs. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Min M 2□F Days Hours 81 515-01-2190 Director 3,1917 Kansas Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 25s4 show traumstic event, the Madical Example I must be not that at 1 Yes 2 No Directo Maryland Prince George Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours after death with the Department of Heelith and Mental Hygiene. In Tabrarial, or itema 23a or 2, any Injury or other traumatic event, the Magical Francisco Pace. 8906 Boxford Court 20708 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11 Marital Status Black White etc. 1 X Yes 2 □ No 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorcad Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 US Army Officer Army 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Verne A. Craven Lettye Ford 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Jean Craven/Wife 8906 Boxford Court, Laurel, Maryland 20708 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, cremetory or other placa) 20c. Location - City or Town, Stete † Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 7/14/99 Arlington, Virginia 21. Signature of Funeral Service Licent 22. Name and Address of Facility Fleck Funeral Home, Inc. the disease, or complications that caused the death. Do not enter art feilure. List only one cause on each line. 7601 Sandy Spring Road, Laurel, Maryland 20707 ar the mode of dying, such as cardiac or respiretory arrest, Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of) Physician/Medical Due to (or as a consequenca of) attending Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detech 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy s certificate hes t director, page 2 s 2000 1 ☐ Yes 2 ☐ No 1 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 20 No Certification: To 1 Suppatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28e. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 26c. Injury at Work? 1 Natural 5 ☐ Pending death. 1 Yes 2 No investigation 2 Accident ofter deatl 6 Could not be 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Different Completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated. 29a. Certifier Medical hedical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and

State Registrar 31. Date filed (Month, Day, Year) 8 1999

. F. OKWARA MD 4000 32. Registrar's Signature

ess of person who completed cause of death (Item 23a) (Type, Print)

w Northern

PKW

Baltimore MI) 21215

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the Meryland

Baltimore, Maryland 21215-0020

that the death certificate be executed

requires

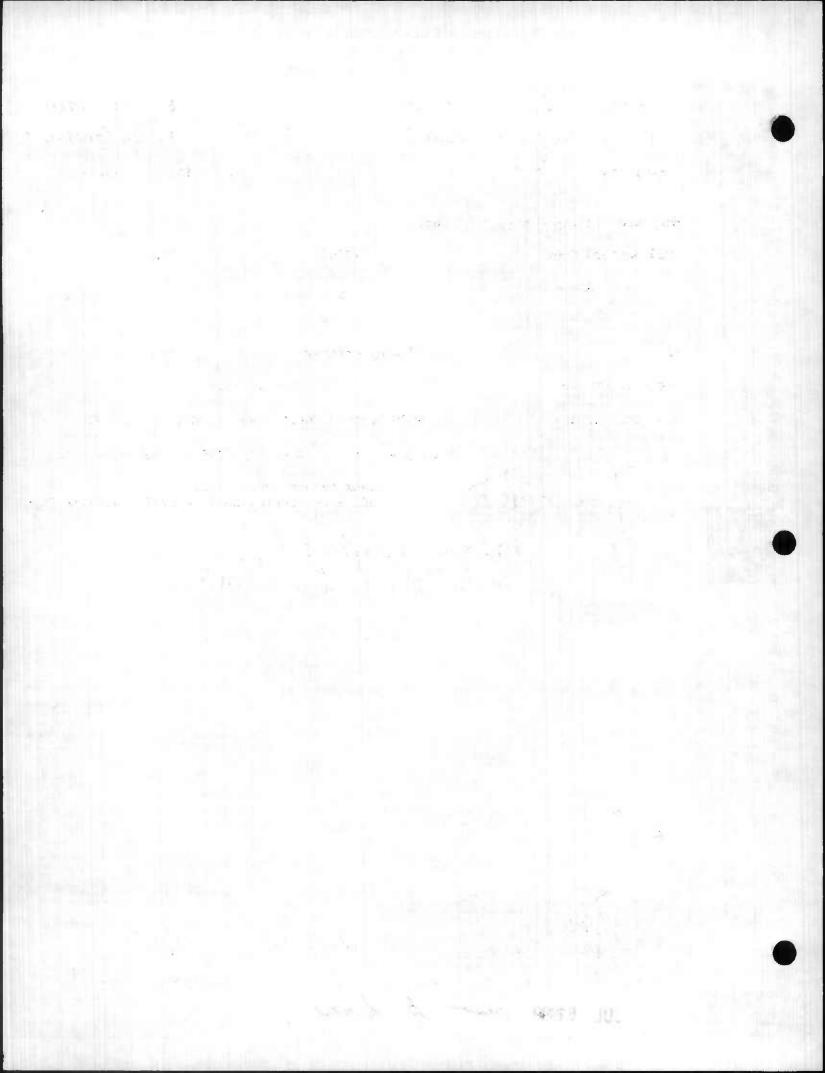
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or Attending Physician:

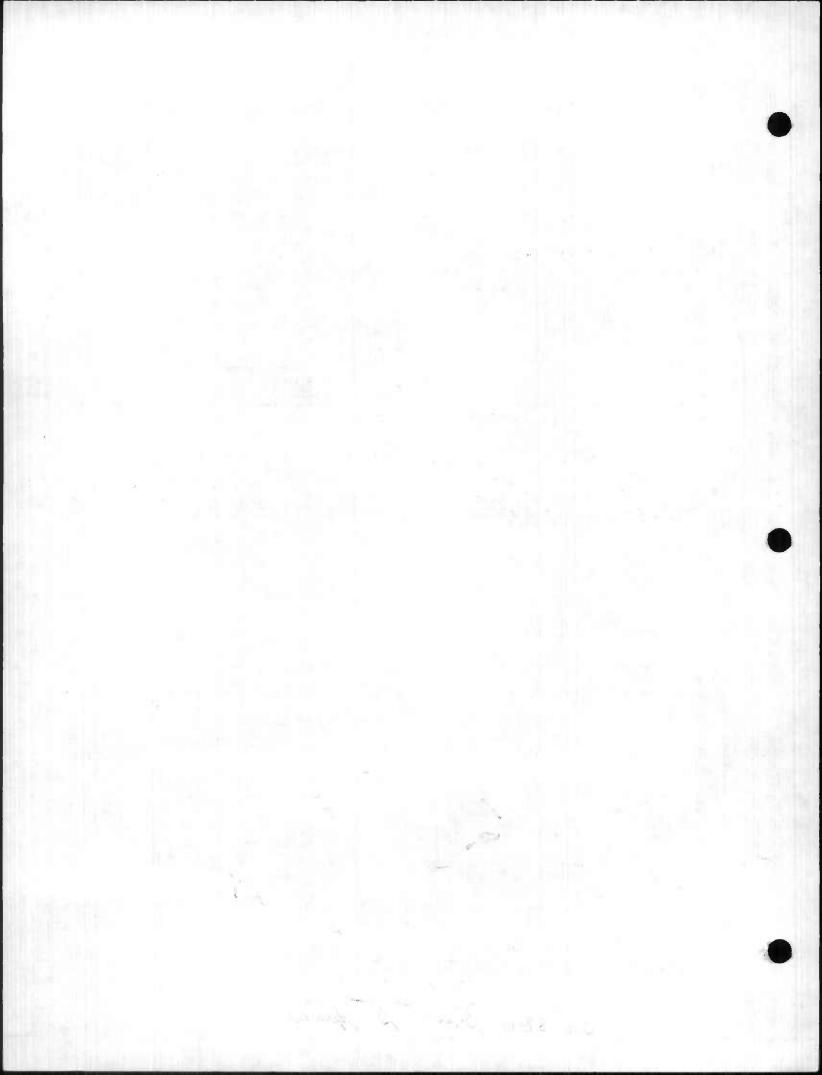
P.O. Box 68760.

Division of Vital Records,



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 5:45 AM July **IRENE** COWAN 111 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 5. Social Security Number of Bultimore N/A If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 1 M 2 X F 96 NOV. 6,1902 Yrs. 215-44-1867 MD Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Directo N/A 28a-f BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code thems 23s or 7202 CHALKSTONE DRIVE 21208 U.S.A. #A-3 Funeral 14. Rece - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 ☐ Never Merried 2 ☐ Married 8 altimore, Maryland 21215-0020 1 Yes 2 No Specify: WHITE Specify: Àq 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Educetion (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 ARTIST ART 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be 19 ment of Health and Mental H lant; if Nem 27 is marked off 88 SAMUEL WALNER ANNTE 19e. Informent's Neme/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LUCILLE WEINBERG / DAUGHTER 7200 CHALKSTONE DR. #B3 - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete Notice 2 ☐ Cremation 3 ☐ Removal from State HEBREW YOUNG MEN CEMETERY 7/4/99 WOODLAWN, MD Other (Specify) 22. Neme end Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final Pulmorary Edema 15 minutes diseese or condition resulting in deeth) Examiner Due to (or es a consequence of): Examiner ardio myopath. 10 years physician and the burial-transit Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Physician/Medical Due to (or es a consequence of): 950 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? Division of Vital Records, P.O. signed by t 1 Yaa 2 No 3 Probably 4 Unknown Aypertension, Mesenteric insufficiency syndrome, Perhyheral by 24b. Were autopsy tindings available prior to completion of cause of death? 24e. Wes an autopsy performed? Completed Varcular disease, Lower Gastraintestinal Bleeding Deep 2 13 No 1 ☐ Yes 2 ☐ No Chronic I or Attending Physician: after death. Director: After this certific funeral director, 25. Was case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 10 2 ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital To the Hospital within 24 hours of To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated 29a, Certifier edical 2 Medical Examiner: On the basis of exeminetion and/or investigetion, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) and menner steted. (Check only one) 29b. Signeture and bits of corsilie 29c. License number 29d. Dete signed (Month, Day, Year) RES-000 July 2, 1999 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Hospital 2401 W. Belvedere ave Sinai D. M. Irlandez M.D. 31. Dete filed (Month, Day, Year) - 32. Registrar's Signature State Registrar 8 1999 **DHMH 16 Rev 6/95** 

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Dete of Deeth **Physician** Manc Month 4b. City, Town, or Location of Death 06 1999 /Medical 4:45am 4a. Facility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** 135 Disney Ct. Owings If Under 24 Hrs. Mills Baltimore Co. 7. Age (In yrs. lest birthday) If Under 1 Yeer 8. Dete of Birth (Month, Dey, Year) Birthplece (Steta or Foreign Country) 5. Sociat Security Number **Funeral** 1 XM 2 ☐ F Deys Hours Yrs. Director 46 053-44-7323 12 31 52 N.Y. Usuel Residence of Dacedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow treumstic avant, the Medical Examiner must be notified at 1 ☐ Yes 2 TNo Director Md Baltimore Co. Owings Mills 10a. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6 Items 23a 135 Disney Ct. U.S.A. Funeral 12. Wes Decedant Evar in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 14. Rece - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours efter on neat of Heatth and Mentel hygiene.

Mrt. If fem 27 is marked other than "natural", or iter marked other than "natural", or iter with the Medical Examine my or other traumatic avant, the Medical Examine my or other traumatic avant, the Medical Examine 1 Never Married 2 Married 1X) Yes 2 □ No If Yes, Give Yeer or Dates: 1 ☐ Yas 🏖 No Specify: à Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedant's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) Collage (1-4or 5+) 12th grade na Inspector U.S. Custom 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be Joseph Douglas Elizabeth Brown 19e. Informent's Name/Relationship (Type, Print) 19b. Maiting Addrass (Street end Number or Rurel Route Number, City or Town, Steta, Zip Code) Gail C. Douglas-Wife 135 Disney Ct., Owings Mills Md 21117 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Ramoval from State permit. Page Department of Important: If any injury or □ Denation 5 □ Other (Specify) Druid Ridge Cemetery 7/9/99 Pikesville, Md 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility March F/H West Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart feilure. List only one cause on each line. 21215 Approximete Interval Between Onsat and Deeth **Physician** Pananeatic Adenocarcinane Five /Medicai Immediate Ceuse (Finel disease or condition resulting in death) Examiner Due to (or as e consequenca of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, laading to Immedieta ceuse. Enter Underlying Cause (Diseesa or Injury that Initiated events rasulting in deeth) Lest Due to (or es e consaguance of): ettending physician Physician/Medical Due to (or es e consequenca of): Pert It. Other alignificent conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detact 1□ Yes 2 No 3 Probably 4 Unknown by Completed 24e. Was en eutopsy performed? 24b. Ware autopsy findings eveileble prior to completion of cause of deeth? this certificate 1 Tes 1 ☐ Yes 2 ☐ No Attending Physicien: 25. Was case referred to madicat exeminer? Be 26. Place of Deeth (Check only ona) Hospital: Othar: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
Injury et 28d. Describe how Injury occurred 1 Yes 20 No Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Tima of 28c. Injury et Work? After 1 A Naturel 2 Accident 5 Pending Investigation 1 Yas 2 No death. Hospital or Attendi 24 hours efter death. Funerel Director: A in by the 3 Suicide 6 Coutd not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Numbar, City or Town, Stete) 4 Homicida To the Hospital
within 24 hours e
To the Funeral C Cartifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the ceuse(s) end mannar as steted.

Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated. Medicai 29a. Cartifier

State Registrar

31. Date filed (Month, Dey, Yeer) JUL 0 8 1999

29b. Signetura end titta of cartifier

32. Registrer's Signatura

30. Nama end addrass of person who completed causa of death (Itam 23e) (Typa, Print)

exile

1838 Greene Tree Rd. Suite 120 2. Registrer's Signatura

29c. License number

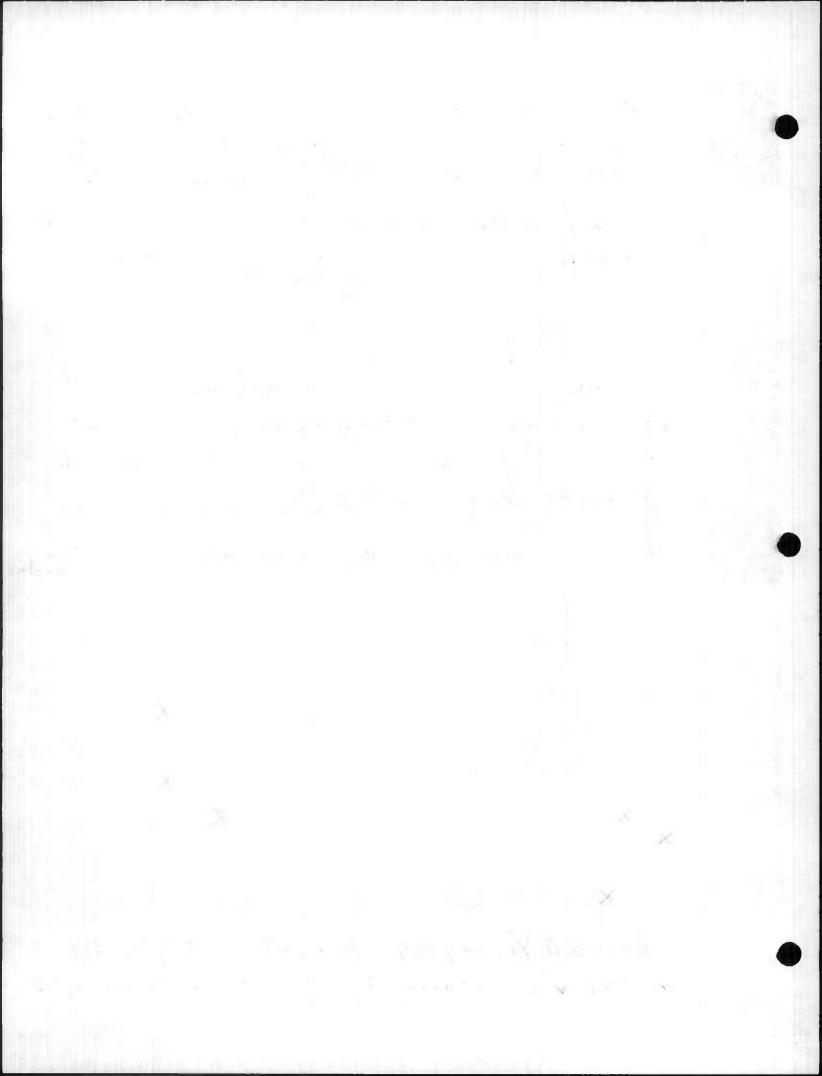
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**DHMH 16 Rev 6/95** 

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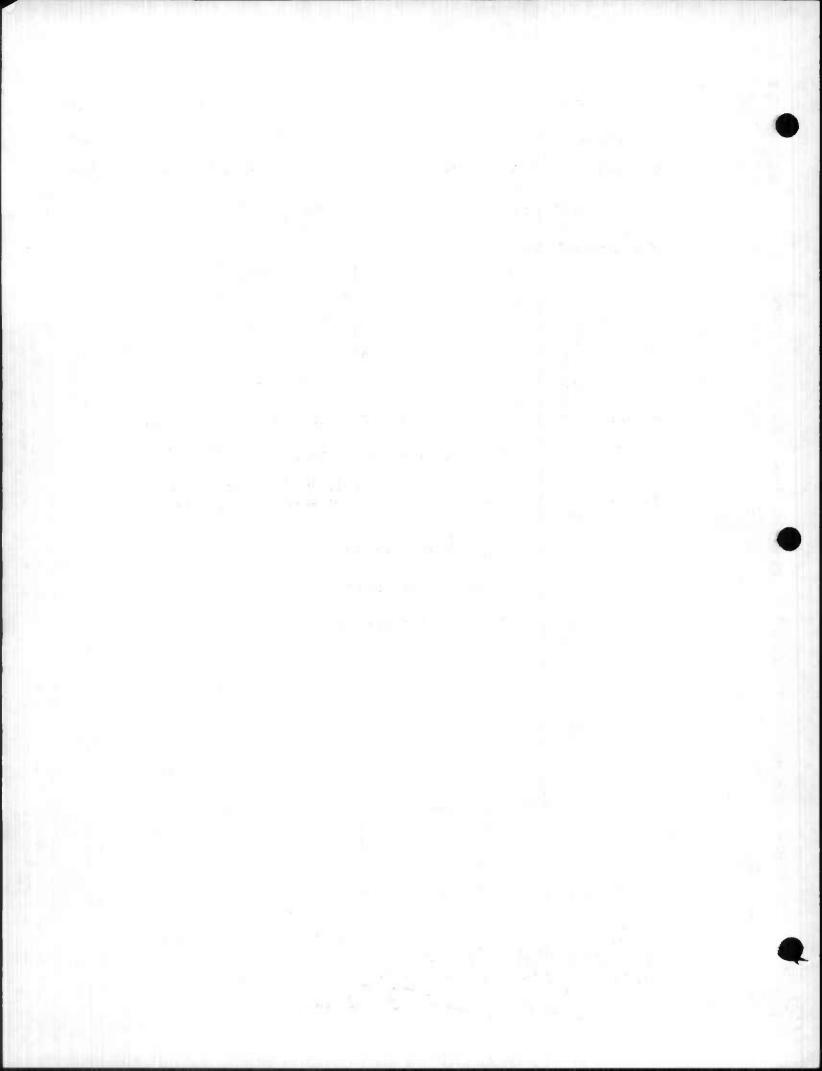
Baltimore, Maryland

Division of Vital Records, P.O. Box 68760,



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** JUNE Dey 1999 OLIVE E DOBRY 15 9:00pm /Medical 4e. Facility Name (If not Institution, give street and number) 4b. Clty, Town, or Location of Death 4c. County of Death Examiner 14 A Glenwood Road Essex Baltimore Hours Min. 8. Date of Birth (Month, Day, Dec. 25 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funerai** Days 1 □ M 25 F Maryland 218-48-1641 94 Vrs Dec. Director Usual Residence of Decedent with the Maryland Show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Md. Baltimore Essex 1 ☐ Yes 2 No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 A Glenwood Road 21221 USA 238 Funeral items ? 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. r than "natural", or item the Medical Examiner filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 Never Married 35 Married Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8th Housewife own home other traumetic event. permit. Pages 1 and 2 should be file Department of Health and Mental. Hy Important: if Nem 27 is marked othe any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Be David Corns Bertha L Duvall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Dobry / husband 14 A Glenwood Road Baltimore Md. 21221 Baltimore. 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removel from State 6/16/99 Baltimore Md. 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 21. Signature of Funeral Service Ligansa 22. Name and Address of Facility Connelly Funeral Home of Essex 10 onn 300 Mace Ave. Baltimore Md. 21221 23a. Part 1. Enter the disease, a complications that coursed the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heer failure, cast only one cause on each age. Approximate erval Betw Onset and Death **Physician** /Medical Immediate Cause (Final Cardiopulmonary arrest disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Cerebrovascular Disease The law requires that the death certificate be executed and Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet Initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. physician Coronary Artery Disease Physician/Medicai the Due to (or as a consequence of): esn signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown Records, Completed by 24a. Was en eutopsy performed? 24b. Were autopsy findings aveileble prior to peed aveileble prior to completion of cause of deeth? has pege 2 1 ☐ Yes 200No certificate 1 ☐ Yes 2 ☐ No of Vital Attending Physician: 25. Was cese referred to medical Be 26. Plece of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5000 Nesidence 6 Other (Specify) 2 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Dey Yeer) 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? Division After 1XXIatural 5 Pending death. 1 TYes 2 No investigation or Attendi efter death Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide filled i 24 hours e Funeral ( Hospital Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the ceuse(s) end menner as steted. 29a. Certifier Medical Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check) To the To the T 29b. Signeture 29c. License number 29d. Dete signed (Month, Day, Year) D 21242 July 6 1999 person who con (Item 23a) (Type, Print) d cause of de 1245 Eastern Blvd. (Dr. Gregory Kelly Baltimore Md. 21221 31. Date filed (Month, Day, Yeer) 32. Registral's Signature State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No." 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day **Physician** JOHN DINAN JULY 6 1999 /Medical 1:06 PM 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1☑M 2□F Yrs **Director** July 15, 1914 218-10-7281 Md. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if Hygiene. other than "natural", or literia 23a or 28a-f show vent, the Medical Examiner must be notified at 1 TYAS 2 NO Directo Md. Baltimore Towson 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1003 Kirkcolm Rd. 21286 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🖾 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: ğ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 2 John's Hopkins Elementary/Secondery (0-12) College (1-4or 5+) Physics 12 +5 Chemical Engineer permit. Pages 1 and 2 should be filed. Department of Health and Mental Hyg Important: If them 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dinan William Catherine Kernan Lo 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1003 Kirkcolm Rd. Towson, MD. 21286 Mrs. Mary A. Dinan/wife 20b. Pteca of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial 7/9/99 Timonium, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Dental 1050 York Rd. Towson, Md. 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** tmmediate Ceuse (Final disease or condition resulting in death) /Medical ABDOMINAL CARCINOMATOSIS Examiner Due to (or as a consequence of) Examiner physician and s the burial-trans Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated Due to (or as a consequence of): Box 68760, certificate be Physician/Medical thet initiated events resulting in death) Last Due to (or as a consequence of): 987 ed by the a 23b. Did tobacco use contributs to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed by PNEUMONIA Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has 2 No 1 ☐ Yes 2 No certificate 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 27. Mepner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Attending 1 Natural 2 Accident 5 Pending investigation or Attending after death. 1 Yes 2 No the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 4 Homicide To the Hospital
within 24 hours a
To the Funeral C
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 24034

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DHMH 16 Rev 6/95

State

Registrar

OSLER DRIVE TOWSON, MARYLAND 21204

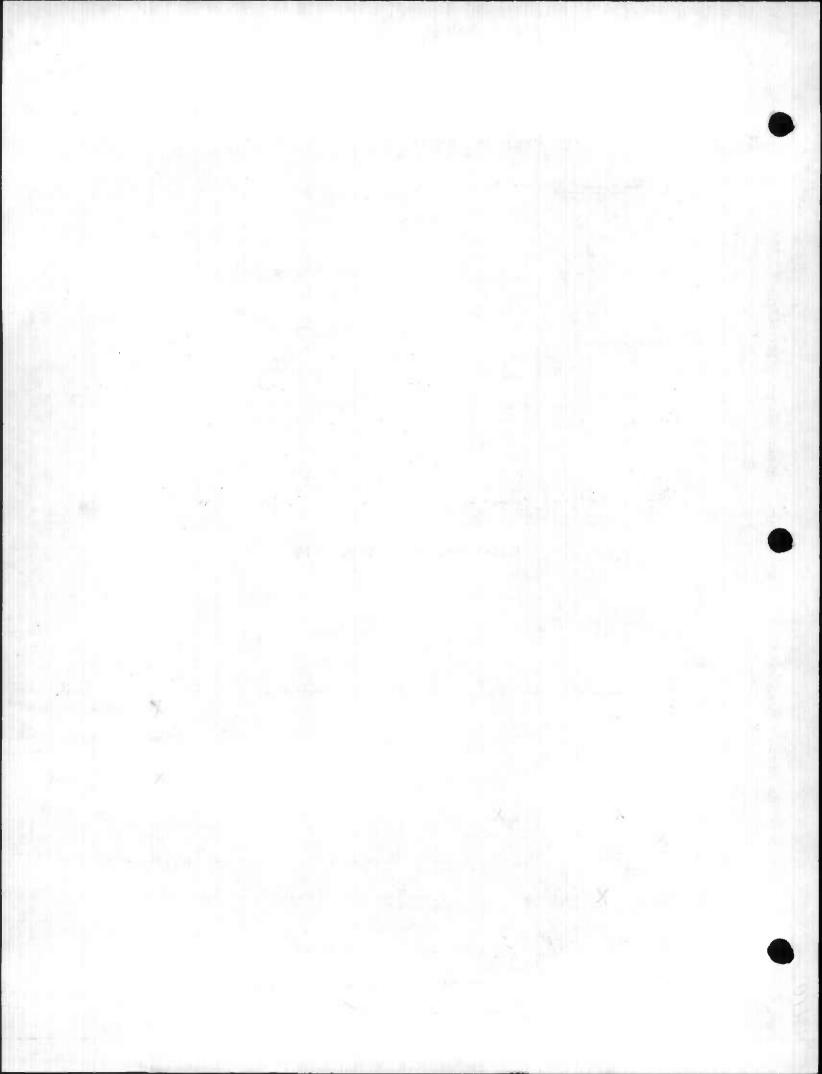
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

TIMOTHY LOW 7601

JUL 0 8 1999

31. Date filed (Month, Dey, Year)



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JOAN. PASFIELD July 5, 1999 5:45A 4a. Facility Name (If not institution, give street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore 5. Social Sacurity Number if Undar 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) November 30, 1926 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York 1□M XXF Days Yrs. 076-22-8954 72 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes XX No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? 525 Windwood Road 21212 USA 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 KXto If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status 1 Naver Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White XX Widowed 4 ☐ Divorced 18e. Decedent's Usuel Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elamantary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Ambrose Pasfield Mildred Eather Horton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael P. Davis 525 Windwood Road Baltimore, Maryland 21212 Son 20a. Method of Disposition XXXIvial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State Dulaney Valley Mem Gar 7/8/99 Lutherville, Maryland □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. ignature of Funeral Soffice License 23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. 6500 York Road Baltimore, Maryland 21212 Approximate Intervel Between Onset and Death MULTIPLE Immediate Ceuse (Finel MYFLOMA diseasa or condition rasulting in death) Due to (or as e consequence of) Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Disease or Injury Due to (or es e consequença of): Due to (or as a consequence of): 23b. Did tobecco use contribute to the cause of death? DULMON ARY 3 Probably 4 Unknown OBSTRUCTIVE 1 | Yes 2 | No 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed?

Examiner Physician/Medical

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> thet Initieted events resulting in death) Last Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC

1 ☐ Yes 2 ☐ No

HOSPICES

5. Was case reterred to medical				26. Plece of Dea	ath (Check only one)	,
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient	3□ DOA	Other: 4 Nursing H	lome 5 Residenca	6 Othar (Specify
7. Manner of Deeth 1	28a. Data of Injury (Month, Day Yeer)		28c.	Injury at Work? 1 Yes 2 No	28d. Describe how in	

 Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide

29a. Certifier 1 Certifying Phyeicien: To the best of my knowledge, death occurred at the time, dete end piece, end due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated.

29d. Data signed (Month, Day, Year)

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State Registrar

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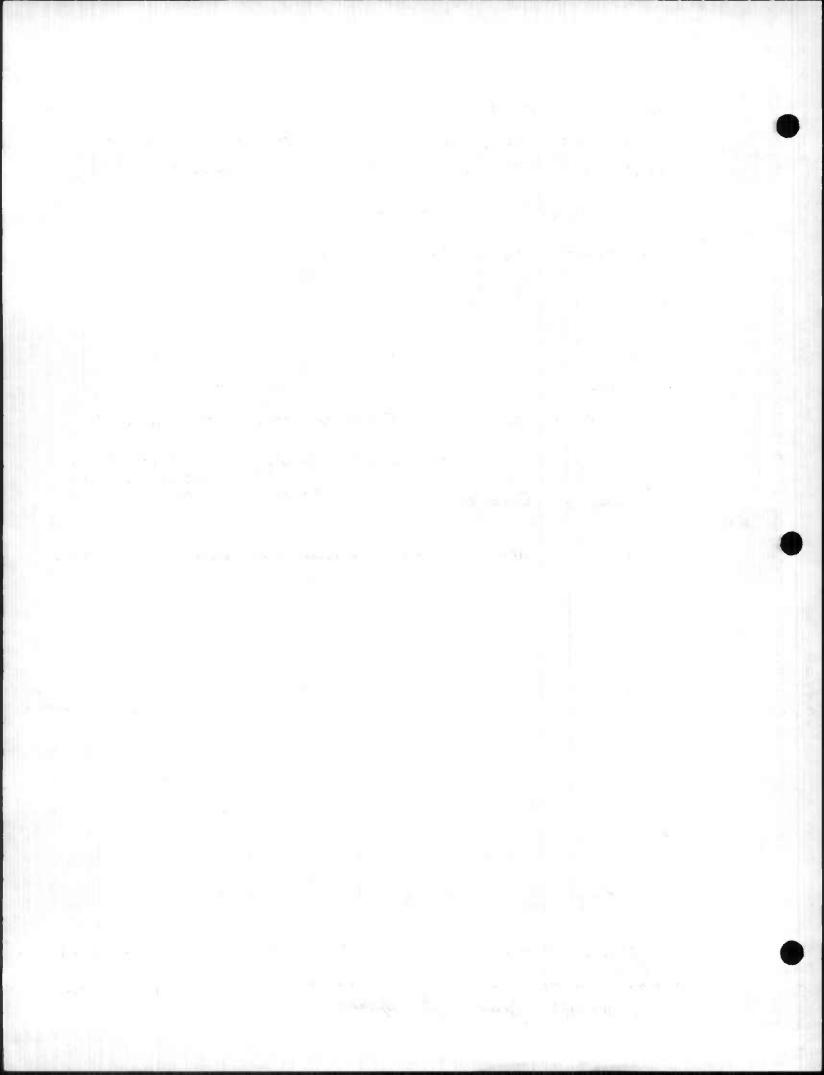
## Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 21439 Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 1999 Margaret Shields Eastridge July 3, 9:30A.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6391 Rowanberry Drive Apt. 119 Elkridge Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Days | Hours | Min. | June 14, 1924 5. Social Security Number 9. Birthplace (State or Foreign Country) Virginia 7. Age (In yrs. last birthday) **Funerai** 1□ M 2⊠ F 229-12-8328 Yrs Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Modical Examiner must be notified at MD Howard Elkridge 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6391 Rowanberry Drive, Apt 119 21227 U.S.A. Funeral death 1 Was Dacedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Pages 1 end 2 should be filed within 72 hours after onent of Heelth and Mentel Hygiene.
Int: If item 27 is marked other than "natural", or iten Iry or other treumetic event, the Medical Execution. Black White, etc. Yes 2 No 1 Yes, Give Yaar or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify Specify: White Completed by 3 ₩Vidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be James Shields Mary Toler 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Robert Eastridge (Son) 5438 Hesperus Drive, Columbia, MD 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 ☑ Cramation 3 □ Removal from State Department of Important: If any injury or once. Balto. Washington Crematory 4 ☐ Donation 5 ☐ Other (Specify) Laurel, Maryalnd 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signatura of Funeral Service Licensee 5555 Twin Knolls Road, Columbia, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heer feilure. List only one cause on each line. **Physician** Immediete Cause (Finel diseese or condition resulting in death) /Medical ATHERO SLLENOTIC CARDISVASCILAR 4 EARS Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last pue the buriel-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? 3 Probably 4 Hilknown 1 Yes 2 No Records, by Completed 24b. Were autopsy findings available prior to completion of causa of death? 24a. Was an eutopsy performed? 1 🗆 Yes this certificate 2 100 1 ☐ Yes 2 ☐ No Division of Vital al or Attending Physicien: The sefter death.

I Director: After this certificated in by the funeral director, pa 25. Was cese referred to medicel Be 26. Piece of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicida 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital o within 24 hours of To the Funaral DI completely filled in Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifian 29c. License number 29d. Date signed (Month, Day, Year) D51860 - MD 30. Name en address of person who completed cause of death (Item 23a) (Type, Print) 3460 ELLICOFF CTR M #103 ELLICOFT CIM MD JONATHAN FISH 31. Date filed (Month, Dey, Year)

JUL 0 8 1999 34. Registrer's Signeture State

Registrar **DHMH 16 Rev 6/95** 



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month ROSA 15 M 99 FRANKLIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c/ County of Deat Examiner Co. Catonsville Baltimore Forest Haven Nursing Home If Under 24 Hrs. 8. Date of Birth (Month, Day, If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 1 M XX Days Year) 212-18-0720 Yrs. Director 81 13 N.C. 06 Usual Residence of Decedent the Maryland 10a State 10h Counts 10c. City. Town or Location r than "natural", or items 23a or 28a-1 show the Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Director MD NA Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1600 Mt. Royal U.S.A. Funerai Ave 21217 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 XNo 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Black, White, etc. 72 hours aftar 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: 3 XWidowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Heelth and Mental Hygiane Important: if Item 27 is marked other than "nany Injury or other treumatic avant Elementary/Secondary (0-12) College (1-4or 5+) 9th grade Factory Worker Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rebecca Durham Samuel Dunn 2 19a. Informent's Name/Relationship (Type, Print) 1615 E. Northern Park Way, Baltimore Md 21239 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Franklin-Son 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Burlel 2 Cremation 3 Removal from State Md 7/10/99 Randallstown, nation 5 Other (Specify) King Memorial Park ure of Funeral Service Doenses 22. Name and Address of Facility March F/H West Wabash Ave, Baltimore Md 21215 nn 4300 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, or heart feilure. List only one cause on each line. Intervel Between Onset and Death **Physician** ATHEROSCLEROTIC CARDIOVASCULAR DISBASE /Medical Immedia o Cause (Final disease or condition resulting in death) **Examiner** Due to (or as a consequence of) Examiner tha bunal-trensit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of): Box 68760. nding physician Physician/Medical Due to (or as a consequence of): etten Pop P.O. ed by the e Part Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown ARKINSONS ns EASE Records, þ 24b. Were autopsy findings aveileble prior to completion of cause of death? Completed 24e. Wes an eutopsy performed? The law egad certificata 1 Yes 26 NO 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 10 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA this 27. Mannes of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After Atten...
after death...
at Director: Af 11 ☑ Netural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide UC Certifying Phyalcian: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and manner as steted.

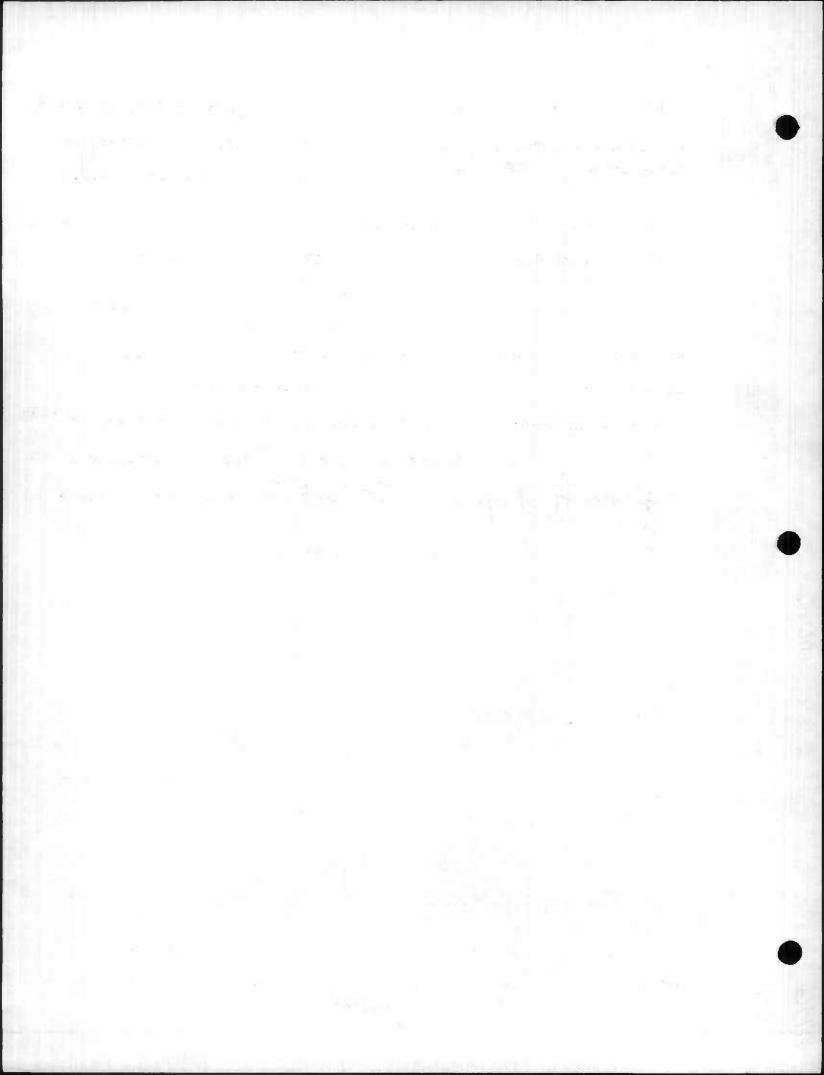
2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date sigped (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ween

HEIGHTS AVE, BALTO MD 2120 8

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7220

35 Registraria Signature



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year BENSON FOLAND JULY 6 1999 4 AM 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HOSPICE OF ocial Security Number BALTO. BALTIMORE CENTER Birthplace (State or Foreign Country) Months Days Hours 120 M 20 F 71 214-24-8319 JUNE 30,1928 MARYLAND Usuei Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes X No BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21209 USA 2505 LIGHTFOOT DR. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. TV Yes 2 □ No 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) COMMUNICATIONS DEPT. OF DEFENSE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LOUIS FOLAND REBA MASEROVITZ 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MRS. JEAN FOLAND (WIFE) 2505 LIGHTFOOT DR. BALTO., MD 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from State 4 □ Donetion 5 □ Other (Specify) OHEB SHALOM MEM. PARK 7/7/99 REISTERSTOWN , MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900REISTERSTOWN RD. PIKESVILLE, MD 21208 23a. Part1 Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart leiture. List only one cause on each line. Approximate Intervet Between Onset and Death Immediate Cause (Final Core house no-the disease or condition resulting in death) Due to (or as e consequence of) Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy nerformed? completion of cause of death? 2000 1 Yes 1 Yas 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 ☐ Yes 2 ☐ No

The law requires that the death certificate be executed Box 68760. 980 signed by the a P.O. Division of Vital Records, this

or Attending

Hospital

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death.

Examiner Physician/Medical Completed by Be

Certification: To funerai 4 hours after death uners! Director: / 3 within 24 hours a Medical

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

r than "natural", or flams 23a or 28a-f show the Medical Examiner must be notified at

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Director

Funeral

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Completed

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the Maryland

filed within 72 hours after

Pages 1 and 2 should be fittered in the fittered in the fittered of the fitter

Physician /Medical

Examiner

21215-0020

Baltimore, Maryland

2 Accident 3 Suicide 4 | Homicide

6 Could not be determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

281. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier

Attending mo

July 7, 1999

21204

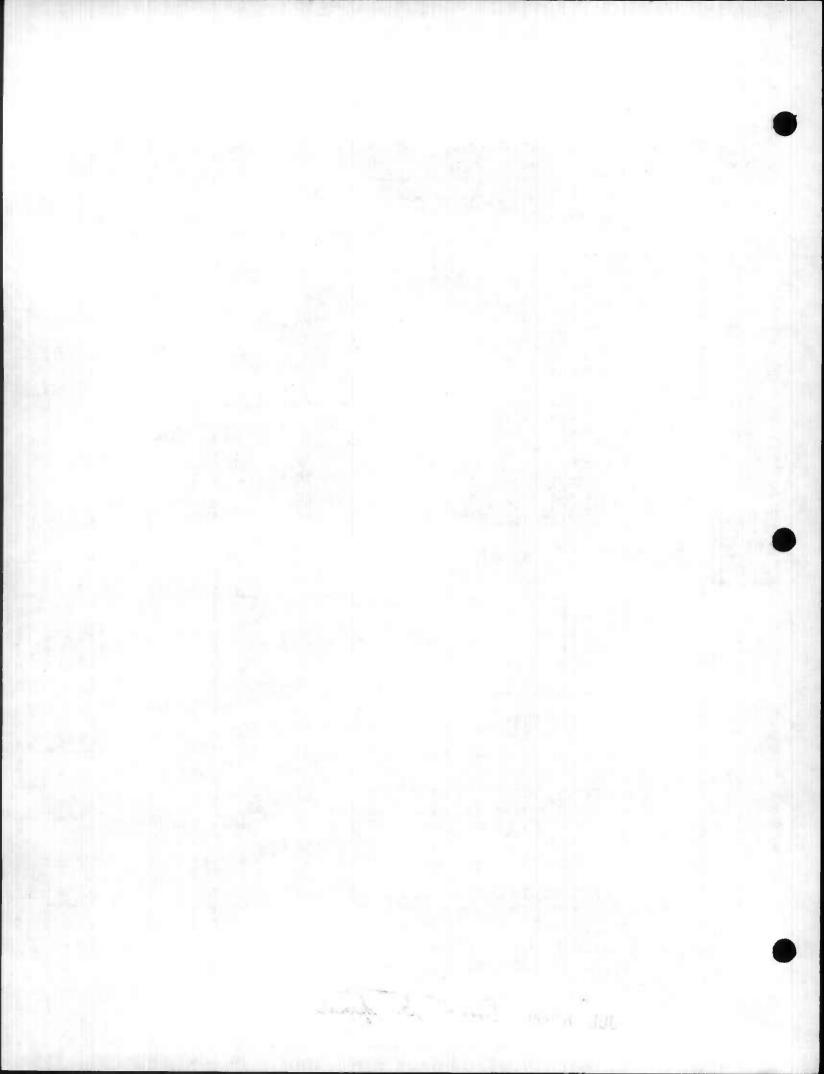
10 State

Registrar

31. Date liled (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenneth M. Greene, mo 6701 N. Cherles St, Sa. 7e 4105 1, 1thmon, mb Kenneth M. Green, mo 32. Pegistrar's Signature

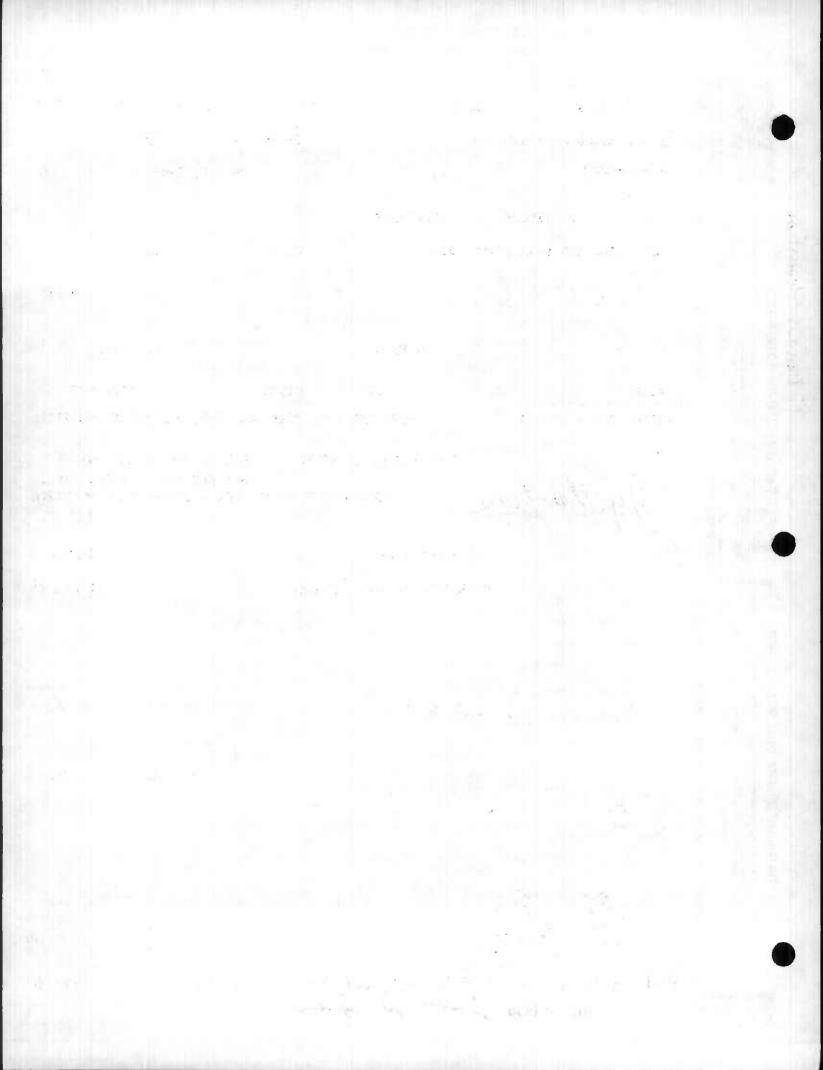


# Pt. Known as Steven fine

	Decedent's Name (First, Michael Control of the	ddle, Last)		Certificate	JI DEALII	2. Date of De	_	-	3. Time of Death
Physician (Martine)	STEVEN	1	NEIL		FINE	July	Day	GGG	725 AM
/Medical Examiner	4a Facility Name (If not institut	tion, give street and number	er)		4b. City, Town, or	Location of Deet			
	Sinai Hospita				Battin	-	N/A		
uneral rector	5. Social Security Number 212–48–8950	6. Sex 7.	Age (In yrs. lest bi	Yrs. II Under 1 Y	ear If Under 24 Hrs ays Hours Min		y, Year)	9. Birthpl Count	ace (State or Foreign try) MD
ž_	Usual Residence of Decedent 10a, State 10b, Coun	ity	10c. City, Tov	n or Location				10	Od. Inside City Limits
28a-f show notified at rector	334-345	BALTIMORE		IMORE					1 ☐ Yes 2 ☐ No
Director	10e. Street and Number		200.00	10f. Zip Co	de		10g. Citizen of V	What Count	try?
	6972 MILBROO	OK PARK DRIV	E #T-3		21215		U.S	.A.	
Examiner must	11. Maritel Status  1 □ Never Merried 2 □ M  3 □ Widowed 4 🛣 Divorce	If Yes Give	s? No	If Yes, specify	ol Hispanlc Origin? (S Cuben, Mexican, Puer No Specify:	Specify Yes or No to Rican, etc.)		e - America ck, White, e	
Completed		ent's Education hest grade completed)	188	Decedent's Usuel O (Give kind of work d	one during most of wo	rking	16b. Kind of Br	usiness/Ind	lustry
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To Be C	ALBERT	S.		FINE	HTLDA			NITZB	FPC
traumatic e	19a. Informant's Neme/Reletio		19	b. Meiling Address (St		urel Route Numb			
THE STATE OF	HILDA FINE /	MOTHER		6972 MILBR					
ary or other	20a. Method of Disposition  1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		te cemete	of Disposition (Neme of ery, crematory or other SRAEL CEME	place)	7/6/99	BALTIM		
any injury or	21. Signature of Funeral Service	Licensee /	,	22. Name and A	ddress of Fecility	SOL LEV	/INSON &		
4 9	by (11)	au Leure		8900 RE	ISTERSTOWN	ROAD -	PIKESVI	LLE,	MD 21208
	23a. Part Lentur de diséase, shock or heart failure. L	or complications that causelist only one cause on each	sed the death. Do	not enter the mode of	dying, such as cardia	c or respiratory a	rrest,		Approximete Interval Between
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iner	Immediate Cause (Final disease or condition resulting in death)	Θ	Theumo						24hrs.
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the buriel-transit	Sequentially list conditions	В		consequence of):	ancer			1/	Umoring
EX -	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	J .						ļ	
dicai	thet initieted events resulting in death) Last	C	Due to (or as e	consequence of):					
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by P!	Brain o	und liver 1	netustas	14			149 ZU NO	0 1100	and Accountment
snould						24a. Was	an autopsy ormed?	eva	ere autopsy findings alleble prior to appletion of cause death?
page 2						10	Yes 200		Yes ALNo
Be C	25. Was case referred to media	cal			26. Place of De	eth (Check only	one)		
\$ P	exeminer?	Hospital:	atient 2 ER/O	utpatient 3 DOA	Other: 4 Nursing	Home 5□Res	Idence 6 Oth	er (Specify	)
	27. Manper of Death  1 Natural 5 ☐ Pene		njury Dey Yeer) 28b.		Injury et Work?	28d. Describe	how Injury occur	red	
	2 ☐ Accident Inve	stigation	Injune Ash *	M Arm street feeten of	1 ☐ Yes 2 ☐ No	281 Lacation	(Street and Numi	her ne Puer	I Route Alumbar
inty	4 Homicide dete	ermined 28e. Place of building,	etc. (Specify)	arm, street, factory, of	lica	City or To	wn, State)	or or nure	r ridute reuniber,
completely filled in by Medical Certifi	(Check only 25 Medic	ying Physician: To the be al Examiner: On the basis	of examination e						
To the Funeral Director. Completaly filled in by the	29b. Signature and title Cont	end menner	stated.	29c Li	cense number		29d. Date signe	d (Month.	Dey, Year)
8	PA	PHAN	7	1	)36709	7	1/10	4	1009
	30 Nome and address of	we	d don'th (thom co-)	(Type Print)	100,-1		0015	(	1771
	Philip Effect	on who completed cause of M.D. (450			Strat #	214, To	1815	n.s.	21204
State	31. Date filed (Month, Day, Yes	(ar)32, Regi	strar's Signature	4	211001	-14,100	י משיש	- 113 1	2120]
Registrar	JUL	8 1999	- 100	1. 1st	our		100		

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DHMH 16 Rev 6/95



þ Completed Be Certification: To the filled in by

Records.

of Vital Physician:

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within 24 hours after death. To the Funerel Director: A

Hospital

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23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 as 2 No 1 1 No 25. Was casa rafarred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Vas 2□ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 1 🖾 Natural 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending invastigation 1 Yes 2 No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 Could not be detarmined 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 29a. Cartifiar 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

State Registrar

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(Check only one)

29b. Signeture end titla of cepti

31. Deta filed (Month, Day, Year)

JUL

8 1999

30. Name and address of person who complated causa of death (Item 23a) (Type, Print) 32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

29d. Dete signed (Month, Day, Year)

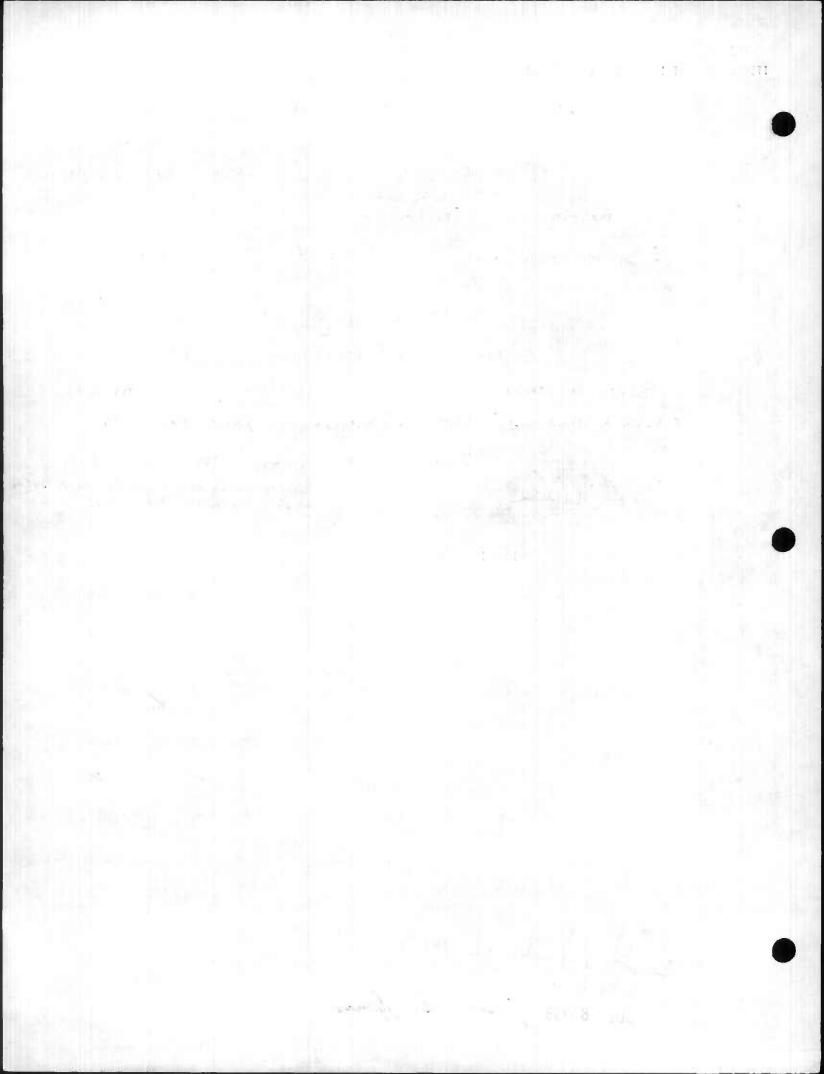
June 30, 1999

3. Time of Death

1:30 P.M.

1 Yes 2 No

Approximata interval Between Onset and Death



#### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item #10c perFH G773 7/8/99 EW 2. Date of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Day Month 1: 30PM 1999 2 **EUGENE** HARRY **GORDON** JUL 4b. Cify, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) LEVINDALE BALTIMORE 5. Sociel Security Number If Undar 1 Year if Undar 24 Hrs. 8. Data of Birth Birthplace (State or Foreign (State 7. Age (In yrs. last birthday) MOM 2□F Months Days Hours Min Yrs. 216-10-1165 Usual Residence of Decedent 10a, Stata 10c. City, Town or Location 10d. Insida City Limits 10b. County BALTIMORE 1 ☐ Yas 2 No 3400 MIDFIELD ROAD BALTIMORE, MD 21208 10f. Zlp Code 10g. Citizen of Whet Country? 10e. Street and Number 3400 MIDFIELD RD. 21208 USA 12. Wes Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Giva Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify. WHITE 3 Widowed 4 □ Divorced 16e. Decedent's Usual Occupation 16b. Kind of Business/Induatry 15. Decadent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondery (0-12) 12YEARS College (1-4or 5+) MANAGER WESTERN UNION 18. Mother's Neme (First, Middle, Meiden Sumeme) 17, Father's Name (First, Middle, Last) **EZRA** LENA (UNKNOWN) **GORDON** 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MALCOLM GORDON/SON 3400 MIDFIELD ROAD BALTIMORE, MD. 21208 20a. Mathod of Disposition 1 ☑ Burial 2 ☑ Cramation 3 ☑ Ramoval from Stata 20b. Place of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State BETH TFILOH CONGREGATION 7/4/99 WOODLAWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Fecility 21. Signature of Furieral Service Licansee SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 23a. Part<sup>1</sup>. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE HTHEROSCLEROTIC CARDIOVASCULAR DISEASE YEAR S Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as e consequence of) 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in tha underlying causa givan in Part I. 1 Yes 2 No 3 Probably 4 Unknown CHRONIC RENAL INSUFFICIENCY ANEMIA 24b. Were autopsy tindings eveilable prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Rasidenca 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury et Work? 1 Neturel 2 Accident 5 ☐ Pending

**Examiner** physician and tha burial-transit certificata be axecuted usa as t datached page 2 cartificata has this funaral Aftar

Examiner Physician/Medical p Completed Be To Certification:

**Physician** 

/Medical

**Examiner** 

MD

Directo

Funeral

by

Completed

**Funeral** 

**Director** 

item 27 is marked other than "natural", or items 23s or other traumatic event, the Medical Examinar must be re

1 and 2 should be filed within 1 Haaith and Mental Hygiena.

Department of Hauth and Important: If Item 27 is my any injury or other.

**Physician** 

/Medical

the Manyland r 28a-f ahow

death

Maryland 21215-0020

SORDON

HARRY

Division of Vital Records, or Attending Physician: aftar death. filled in by Hospital 24 hours

To the Hosp within 24 hor To the Fune complataly fi

29b. Signature and title of cartifier Eytwar

3 Suicide

29a. Certifier

4 Homicide

(Check only

ATTENDING

PHYSICIAN

32. Registra s Signature . -

Place of Injury - At home, ferm, streat, factory, office building, etc. (Specify)

1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 Yes

2 🗆 No

25610

29d. Data signed (Month, Dey, Year) JULY 2.

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

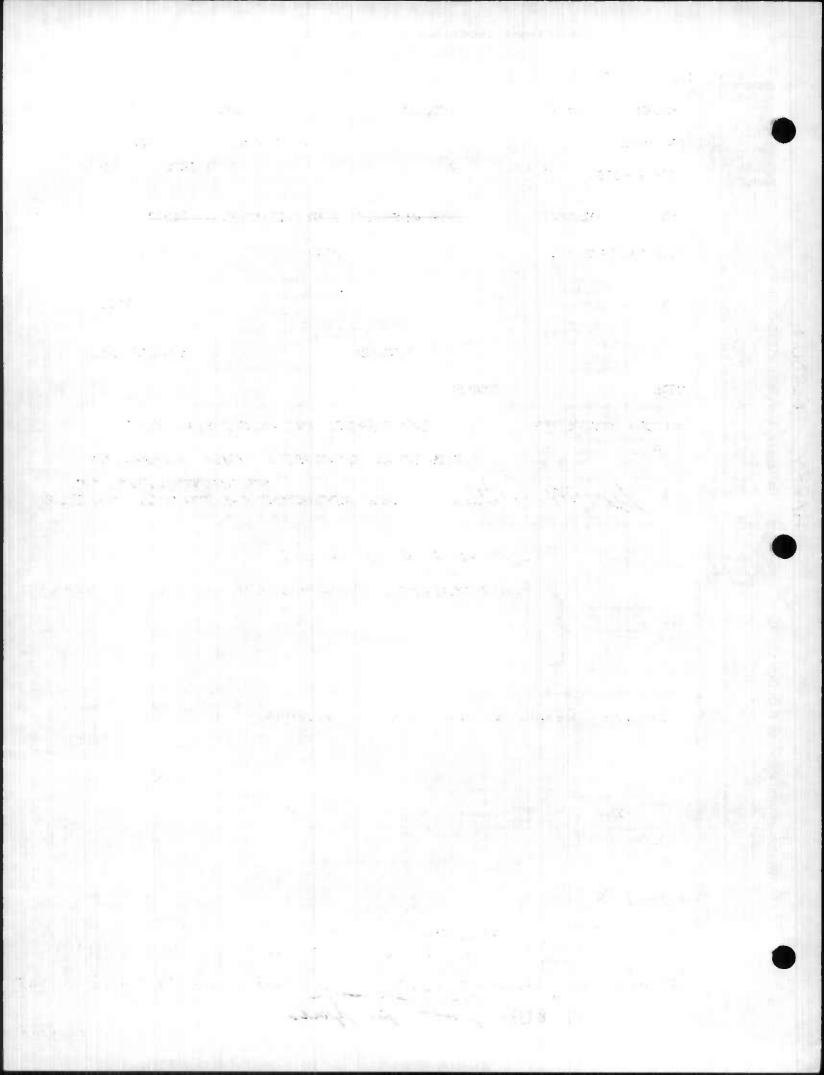
investigation

6 Could not be determined

LEVINDALE 2434 WEST BELVERDERE AVENUE BALTIMORE MD 21215 SET HTWAR M.D. 31. Dete filed (Month, Day, Year)

State Registrar

edical



#### Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 3. Time of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) **Physician GERSCH** 1999 ALBERT S. :45 pm July /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not Institution, give street and number) Examiner Sinai Hospital of Baltimore Baltimore N/A Hours Min. 8. Date of Birth (Month, Day, MAY 15, If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Days 1 MM 2 F 212-09-1425 90 Yrs. MD Director Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow 7 is marked other than "naturel", or items 23a or 28a-f ahov treumetic event, the Woolcal Examiner must be notified at MD BALTIMORE BALTIMORE 1 TYes 2 NO Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11 COBBLESTONE COURT #1A 21215 U.S.A. 'naturel', or Items 23a Funeral filed within 72 hours after death 12. Wes Decedent Ever In U,S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Maritel Stetus 1 ☐ Never Married 2 X Married WWII 1 Yes 2 XNo Specify: WHITE P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene 8 MEAT CUTTER FOOD Pages 1 and 2 should be filed an nent of Health and Mental Hygic int: if item 27 is marked other 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) **GERSCH AARON ESTHER** SIEGEL 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21158 19a. Informant's Name/Relationship (Type, Print) MARSHA ROBINSON / DAUGHTER 1282 HUMBERT SCHOOLHOUSE ROAD - WESTMINSTER, MD Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: if it eny Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetlon 5 ☐ Other (Specify) MARYLAND VETERANS CEM. 7/6/99 OWINGS MILLS, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. ew 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. 1. I only on cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) metastatic Lymphoma Examiner Physician/Medical Examiner attanding physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) that the death certificate be axed Due to (or as a consequence of) 88 23b. Did tobacco use contributa to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2 No 3 Probably & Unknown Division of Vital Records, by The law requires 24b. Were autopsy findings available prior to should 24a. Was an autopsy Completed peen s completion of cause of deeth? certificate has 1 Yes 2 No 1 Yes No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physicities 24 hours after death. To the Funeral Director: After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide 29e. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner as stated. Medical npletaly (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 16 Rav 6/95

31. Date filed (Month, Day, Year) JUL 8 1999

Smith

30. Name and eddress of person

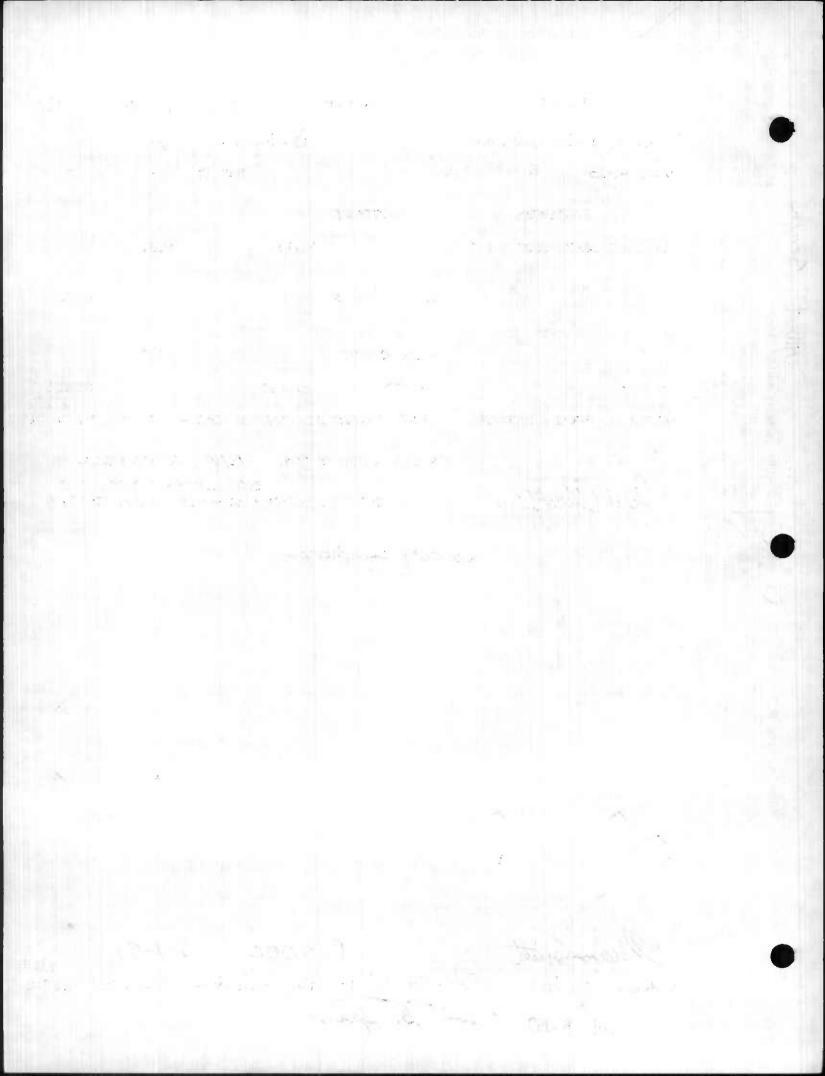
Morrous

32 Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

KES 000

Sirai Hospital 2401 West Belvedere Avenue Battimore M.D.



Physician (Modical Examinor)  Republy Name (if not introduce) proteint for control control of Deep No. (1) p. (2) p. (3) p. (4)						Certifica	te of	Death		Reg.	No.			
Barbara P. S. Godbee  Examiner  Exam	Dharia		1. Decedent's Name (First, Middle, La	ast)							Dev	Veer	3. Time of Dea	ith
## Refull where direct entitions or severe and number   Aer County to Death   Aer County of Death   Aer County			Barbar	a P. S. Go	dbee								11:38A	M
Social Security Number   2.5 See   2.5 See   2.7 -2.7 See   2.7			4e. Fecility Neme (If not institution, gir	e street and number)			-	4b. City, Tow	m, or Location of	Deeth	4c. County o			
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Exemples of the part of the pa	It, or items		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X N If Yes, Give	12/3	If Yes, sp	ecify Cube	en, Mexicen,	in? (Specify Yes Puerto Rican, etc	or No-	Black	, White,	etc.	
Elementary/Secondary (o.12)   College (1-4or 5+)   Sales Clerk   Retail Store	2 hou	B	15. Decedent's E	ducation	16a. I	Decedent's Us	ual Occup	ation		16t	. Kind of Bus	siness/inc	lustry	
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South Companies   Continue   Co	al Hy I othy		17. Father's Name (First, Middle, Las	")							den Sumame	)	1	
Barbara A. Kelly / Daughter  117 Cherry Valley Road Reisterstown, Maryland  20a. Membed of Disposition  XI Burial 2 Chematon S   Denove I from State  20b. Place of Disposition (Name of Disposition)  XI Burial 2 Chematon S   Denove I from State  20b. Place of Disposition (Name of Disposition)  XI Burial 2 Chematon S   Denove I from State  20b. Place of Disposition (Name of Disposition)  XI Burial 2 Chematon S   Denove I from State  20b. Place of Disposition (Name of Disposition)  XI Burial 2 Chematon S   Denove I from State  20b. Place of Disposition (Name of Disposition)  XI Burial 2 Chematon S   Denove I from State  20b. Place of Disposition (Name of Disposition)  XI Burial 2 Chematon S   Denove I from State  20b. Place of Disposition (Name of Disposition)  XI Burial 2 Chematon S   Denove I from State  20b. Place of Disposition (Name of Disposition)  XI Burial 2 Chematon S   Denove I from State  20b. Place of Disposition (Name of Disposition)  XI Burial 2 Chematon S   Denove I from State  20b. Place of Disposition (Name of Disposition)  20b. Place of Disposition (Name of Disposition (Name of Disposition)  20b. Place of Disposition (Name of Disposition)  20b. Place of Disposition (Name of Disposition (Name of Disposition)  20b. Place of Disposition (Name of Disposition (Name of Disposition)  20b. Place of Disposition (Name of Disposition)  20b. Place of Disposition (Name of Disposition (Name of Disposition)  20b. Place of Disposition (Name of Disposition)  20b. Place of Disposition (Name of Disposition (Name of Disposition)  20b. Place of Disposition (Name of Disposition (Name of Disposition)  20b. Place of Disposition (Name of Disposition (Name of Disposition)  20b. Place of Disposition (Name of Disposition (Name of Disposition)  20b. Place of Disposition (Name of Disposition)  20b. Place of Disposition (Name of Disposition)  20b. Place of Disposition (Name of Disposition)  20b. Place of Disposition (Name of Disposition)  20b. Place of Disposition (Name of Disposition)  20b. Place of Disposition (Name of Dispo			Julian C. Somers											·
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Physician Medical Examiner    Physician Medical Examiner   Approximate shows on heart eliure. List only one course disease, or completence and be shown or heart eliure. List only one course disease or condition resulting in death)   Due to (or as a consequence of):	Depenit Dependent Import		21. Signeture of Funerel Service Libe	Knah	1				Leonar					
Sequentially list conditions can be set on sequence of the seq	/Medical Examiner	ner	disease or condition		Due to (or as a co	onsequence of	):		iden	£		1	Onset and Deeti	1
The state of the control of the cont	ding se as	Medical	that initieted events	· 44/2	Due to (or es e co	onsequence of onsequence of	): ):							
The state of the s	death e atte d for	icia	Part II. Other aignificent conditions	contributing to death hu	t not resulting In	the underlying	ceuse div	ren in Part I	23b	. Did toba	cco use con	tribute to	the cause of de	ath?
24e. Wes en eutopsy performed?  24e. Wes en eutopsy performed?  24e. Wes en eutopsy performed?  24e. Wes en eutopsy performed?  25e. Plece of Deeth (Check only one)  25e. Plece of Deeth (Check only one)  27e. Plece of Deeth (Check only one)  27e. Plece of Deeth (Check only one)  28e. Dete of Injury  28e. Injury et Work?  27e. Manner of Deeth  28e. Injury et Work?  28e. In	that the ed by th detech		Anoemia		The roughing in	The underlying								
25. Was cese referred to medicel examiner?    25. Was cese referred to medicel examiner?   26. Plece of Deeth (Check only one)   27. Manner of Deeth   1   1   1   1   1   1   1   1   1	aw requir	pleted t							24e.	Wes en e performed	utopsy 1?	ava	aileble prior to appletion of ceuse	
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The control of the	clan: ertific		25. Was cese referred to medicel examiner?	11 - 2 1					of Deeth (Check	only one)				_
1   Meture    2   Accident   3   Sulcide   4   Homicide   5   Pending investigation   6   Could not be determined   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number of Ru	hysi this c			1 L Inpatier			DOA	4 Mun					1)	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signeture and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	ing After	cation:	1 ☐ Neturel 5 ☐ Pending investigation	(Month, Day		jury				cribe how I	njury occurre	əd		
Darkon mo D 31464 716/95	De o		4 Homicide determined	building, etc	(Specify)				City	or Town, S	tate)			
Darkon mi) D 31464 716 99	Hosp 24 hot Fune tely fi	licai	(Check only 2 Medical Example 12	miner: On the basis of	examination and	death occurre /or investigation	d et the tir n, in my o	ne, date end pinion, deeth	place, and due to occurred et the	o the ceus time, dete	e(s) end mar and place, a	nner as st nd due to	eted. the ceuse(s)	
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30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)	F 2 5		Dra AA		m	(1)	D	314	64	250.	7/6	19	5	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SITO AII3 A-HASHMI, &21, N. Eulaw Ff finite 305 Ralt. MI				Plane		Type, Print)	Sut	24.0	t fruit	- 71	ادل ا	211	t MD	2
State 31. Dete filed (Month) Gay, Year 1999 32. Reductions of the filed (Month) Gay, Year 1999 32. Reduction	St	ate		13.1111	,	6	Sa.	1	JANU	0	7		1 - 110	

Registrar



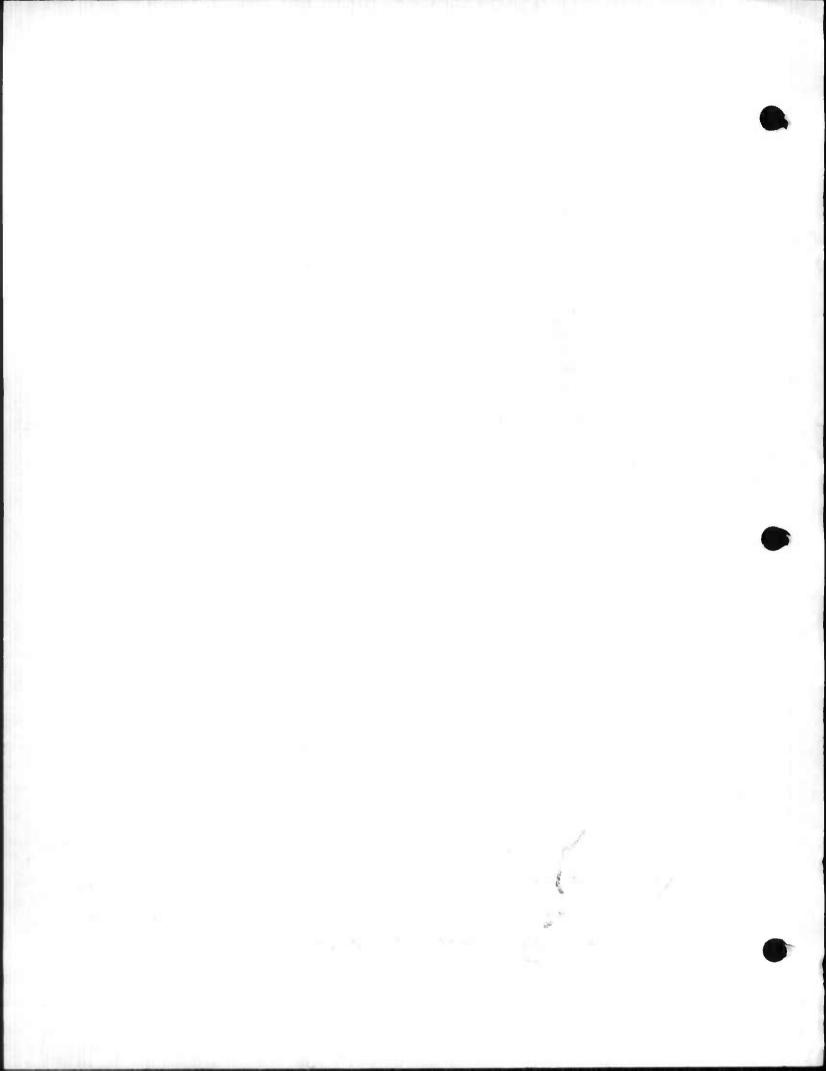
DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTRONING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	AL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	72 hours after death with the State Dept. of Heatth and Mental Hygiene prior to burlal, cremation, or removal.	If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
THE HOSPITAL OR ATTENDING	THE FUNERAL DIRECTOR: After this	be filed within 72 hours after death with	MPORTANT: If item 28 is marke	

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.

-	REGISTRAN		U	EKIIF	CAL	E UF	DEA	I FT		REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Lest)	.£3.11							2. DATE (	OF DEATH	AY	YEAR	3. TIME OF OEATH	
	Roxanne Kaye Hat								6	30		99	1225 Am	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. le:		MONTHE DAVE MOLINE MIN (MON					F BIRTH Day, Year)	PLACE (State or Foreign			
	220-68-5892	1 🗆 M 2 🔀 F	44	YRS.						2, 1		54 Washington, DO		
œ	9a. FACILITY NAME (If not institution, give st 1134 Bacon Ridge						OR LOCATI		EATH		9c. COL	INTY OF O	EATH	
5	RESIDENCE OF DECEDENT	Road			Cı	rown	svil.	Le			Aı	nne A	rundel	
DIRECTOR	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN	OR LOCA	TION					T	10d. INSIDE CITY	
	MD Anne Ar	unde1		Cr	owns	svil	le						LIMITS? 1 VES 2/ NO	
A	10e. STREET AND NUMBER						. ZIP COD	E			10g. CIT		HAT COUNTRY?	
FUNERAL	1134 Bacon Ridge	Road					21032	2			USA	A		
2	11. MARITAL STATUS  1 ∑Never Married 2 ☐ Married	12. WAS OECEDEN FORCES? 1	T EVER IN U.S. AF	MED	13.	WAS DEC	ENDENT (	OF HISPAN	VIC ORIGIN?	(Specify Yea	or No-	14. RACE	— American Indian, White, atc.	
BY	3 Widowed 4 Divorced	IF YES, GIVE W	MR OR DATES				2 AND			can, etc.)		Specif		
	15. OECEDENT'S EDUC	CATION	Me DE	CEDENT'S	UBUA: O	COLIBATIO			Lag				WILLEE	
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	completed)	(G	live kind of v	vork done	during mo	at of world	ng	166.	KIND OF BUS	SINESS/IN	DUSTRY		
립	10	College (1-4 or 5 d	F)	ishwa						Janito	ria1			
8	17. FATHER'S NAME (First, Middle, Lest)						18. MOT	HER'S NA		ddle. Maiden				
ш	Norman Lee Hatfi	e1d					Nar	cv .	Tean (	Carper	iter			
6	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	AODRES	S (Street a	nd Number	or Rural I	Route Numbe	r, City or Town	n, State, Zi	p Code)		
٦	Norman Lee Hatfi	eld/Fath	er :	1134	Baco	n Ri	ldge	Road	i, Cro	wnsvi	ille,	MD	21032	
	29e. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Remo	oval from State	20b. PLACE A	meton, or of	ther pleasel				DATE			City or Tov		
	4X Donation 5 Dther (Specify)	//	Anator	nic G	ift	Four	ndati	on	16/30	Lau	rel.	Mar	vland	
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE /			22.	NAME AF	ID ADDRE	SS OF FA	CILITY	e, Inc				
	- HOMINOC	MYCU	the)									. m o 1	MD 20707	
BY PHYSICIAN: MEDICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  PART II. Other aignificant conditions  DID TOBACCO USE CONTR  25. WAS CASE REFERRED TO MEDICAL EXAMINER?  27. MANNER OF DEATH  1 Natural 5 Pending Investigation	DUE TO DUE TO DUE TO	USE OF DEA 26. PLAC ER/Outpatient 3 INJURY	DUENCE OF DUENCE OF CABUITING I	n the ur  S	NO Conly one) R: sing Hom 28c. INJ	UNC	ERTAIN	N D	24a, WAS AN. PERFOR 1 YES 2 Specify) RIBE HOW IN	MED?		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
- 1	3 Suicide 6 Could not be	26a. PLACE Of building	F INJURY — At ho	me, farm, s	treet, fact	lory, office	)		28f. LOCAT	ION (Street a	nd Number	or Rural Ro	oute Number,	
ED	4 Homicide determined								City or	Yown, State)				
COMPLE	29s. CERTIFIER (Check only one)  1 CERTIFYING PHYSIC 2 MEDICAL EXAMINER	HAN: To the best of	my knowledge, de	ath occurre	d at the t	ime, data	and place,	and due	to the cause	e(a) and man	ner as stat	ted. ne cause(a)	and manner as stated.	
	296. SIGNATURE AND TITLE OF CERTIFIER	925 1					29c, LICE	NSE NUM	IBER	T	29d. DAT	E SIGNED (	Month, Day, Year)	
	plus Ille	n win	V				1	307	218		<b>&gt;</b> /	6-30	59	
-	NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	E OF DEATH (ITER	4 27) (Type,	1									
	Jour Jackson fell	7003	Lesdec	of f	Ku	4	4100	te	mag	oles,	Les	20	801	
	31. DATE FILED (Month, Day, Year)	32. REGISTRA	R'S SIGNATURE	6		1		<i>A</i> .						
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	6.0			-	-								OHMH-18 Rev 1/89	

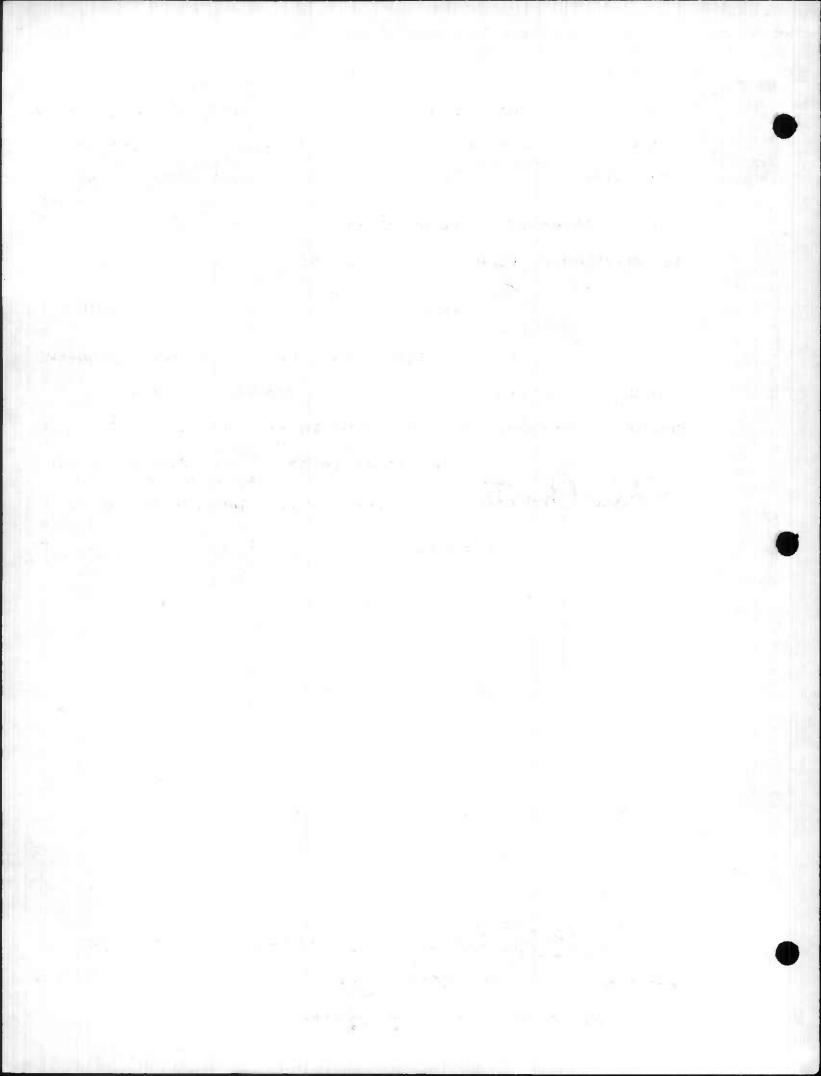




# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 2. Dete of Death Month Dey Year

		Decedent's Name (First, Middle, L	act)	C	ertificate of	Death		Reg. No.	4	2 Time of Death
Physici	an						Month	Dey	Year	3. Time of Death
/Medic		4a. Facility Name (If not institution, g				4b. Cify, Town, or L	ocation of Deat	h 4c. County	999 of Deeth	9:30AM
		MANOR CARE	- RUXTO	A 1		PUXTO	A.)	RA	LTIMO	DE
Funeral				ge (In yrs. last birthd	Months Days		8. Dete of Bir	th W Year	9. Birthpla	ce (Stete or Foreign
Director		215-14-0581 Usual Residence of Decedant	10M 2UF	76 Yrs	. Worth's Days	nours Mill.	NOV. I	OPE		10
with the Meryland a or 28a-f show Les norffied at	J.	10a. State 10b. County		10c. City, Town or	Location				100	I. Insida City Limits
the N	Funeral Director	MD BALT	MORE	LUTHER	10f. Zip Code			10g. Citizen of N	Mhat Countr	
	ā							i il	C A	, ,
death ms 23	Jera	26 BRAMLEIG 11. Marital Status	12. Was Decedent	Ever in U,S.	3. Was Decedent of If Yes, specify Cul		ecify Yes or No	- 14. Rac	a - Amaricar	Indian,
or he	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forcas  1  Yas 2   If Yes, Give Yaar or Datas:	No WWII	If Yes, specify Cul	-	Rican, etc.)	Specify.	ck, Whita, at	
72 hours "netural",	ted	15. Decedent's E	ducation		cedent's Usual Occu	pation		16b. Kind of B	WH usinass/Indu	
within 7 ene. than "r	Completed	(Specify only highast gi	Collega (1-4or	5+) (G	cedent's Usual Occu iva kind of work done a. DO NOT use retin	a during most of worked)	king			
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d oth	Be	17. Fether's Name (First, Middle, Las	1)			18. Mother's Nam	a (First, Middle,	, Malden Sumen	ne)	
nd 2 should be filed w Ith and Mental Hygie 27 le marked other tr traumatic event, tr	2	JAMES H						SHIMP		
12 sh n and le rr		19e. Informant's Name/Ralationship			ailing Address (Stree					
a E E		MARGARET 5. HAS  20a. Method of Disposition  1 Buriel 2 Cremation 3	SENET, SPO	DUSE 26	BRANLE	IGH RD.	LUME	ZVILLE	MO.	21093
permit. Peges 1 Department of H Important: If ite any injury or ot				cametary,	rematory or other pla	ace)	Date	20c. Location -	City or Town	n, State
rtmer rtant:		4 Donation 5 Other (Spec		DEVID	2106E CEN	I ETERY	1999	PIKES	TILLE	MD
permit. Peg Department Important: I any injury o		21. Signature of Funeral Service Lice	nsaa		22. Nama and Addr	ess of Facility EV	this cha	PEL OF	CHIM	52
		more G	malo		3372 AO	ek ed.	TIMONI	UM MD	. 210	93
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cause one cause on aach li	d tha death. Do not ne.	enter the mode of dy	ing, such as cardiac	or raspiratory a	rrest,	li li	pproximata itarval Batween
Physician /Medical		Immadiate Ceusa (Final diseasa or condition	5	TROK						Touths.
Examiner		resulting In death)	a/	Due to (or as a con	5-50-1					(04/8).
ed sit	nlne		b						į	
requires that the death certificate be assocuted een signed by the attending physicien and hould be datached for use as the burial-transit	fedical Examiner	Sequentially list conditions, if eny, leading to immediata causa. Enter Undertying Cause (Diseese or Injury that Initieted events resulting In death) Lest		Due to (or as a con	sequenca of):					
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nificete ng physi as the t		resulting in death) Lest		200 10 (01 43 4 001).	sequence ory.					
eath cer attendir for use	Physician		d						1	
ha at hed fo	SCI	Part II. Other algnificant conditions	contributing to death b	ut not resulting in the	a undarlying cause g	iven in Part I.	23b. Did	tobacco uae co	ntribute to ti	ne cause of death?
es met me de igned by tha a be datached f	by Phy						10	Yes 2 No	3 Probei	bly 4 Unknown
v require been sig should b							24a. Was	en eutopsy rmed?	availe	autopsy findings abla prior to
hes the start and start an	Completed								of da	oletion of cause ath?
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this certificate	Be	25. Was case referred to medical examiner?	Hospital:			28. Place of Deal				
alth is	7	1 Yas 2 No  27. Manner of Death	28a. Data of Inju		ient 3LI DOA	4 Nursing Ho		dence 8 Oth		
After fune	ton	1 Naturel 5 Pending 2 Accidant Invastigation	(Month, De	y Year) Injur	y Wo	ork? Yes 2 No	200. Describe	now injury occur	160	
Attending or death. octor: After by the fune	flca	3 Suicide 6 Could not I	000 51000 0640	ury - At homa, farm,	straet, factory, office		28f. Location (S	Street and Numb	er or Rurel F	Route Number,
s after	Certification:	4 Homicide		c. (Specify)			City or Tov	vn, Stata)		
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29e. Certifier (Check only one) 1 CertifyIng P. 2 Medicat Exa	nyalcian: To the best miner: On the basis o and mannar st	axamination and/or	ath occurred at the ti	ime, date end placa, opinion, daath occur	end dua to tha red at the tima,	causa(s) and ma date end placa,	nnar as state and due to th	ed. na causa(s)
of the	Ž	29b. Signature and titla of condition	and maintai S	p.,00.	29c. Licen	se number		29d. Date signe	d (Month, De	y, Year)
P S P Ó		1111	ONLO	dian	10-	12849	,	7-6	1-90	7
_	-	30. Nama and address of person who	completed cause of a	laath (Item 23s) (Tur	ne Print)	12849 R Dr.		, 0		-
,			1 MD	7600	OSLE	R Dr.	Tows	ON. M	1d. 5	2/204
	te	31. Dete filed (Month, Day, Year)		ar's Signature						

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Wayne Huff JULY 6, 1999 19:17 /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Hospital Baltimore If Under 1 Yaar Date of Birth (Month, Day, Year)
June 14,1920 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foreign **Funeral** Months 1 X M 2 □ F Days Hours Min. 341-05-3941 Oklahoma 79 Yrs. Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Medical Examinar must be notified at MD 1 ☐ Yes 2 No **Baltimore** Catonsville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. 315 Ingleside Avenue Funeral 21228 death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health end Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Item any Injury or other traumatic event, the Mental Exercis 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) Collega (1-4or 5+) UNK UNK UNK 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) UNK UNK 0 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Basil Boyce (Administrator) 315 Ingleside Avenue, Catonsville, MD 21228 20b. Pieca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 7/9/99 Western Star Cemetery 22. Name and Address of Facility Witzke Funeral Homes, Inc. e of Funeral Service Des 1630 Edmondson Avenue, Catonsville, MD 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in death) DSIS nours Examiner Due to (or as a consequenca of) Examiner UNKNOWN nevmania ettending physician end for use as the bunal-transit certificate be executed Sequantially list conditions, if any, leeding to immediate causa. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco was contribute to the cause of death? the ( 1 Yes 2 No 3 Probably 4 Unknown 45 rillation ğ 24b. Were autopsy findings available prior to 24a. Wes en eutopsy performed? Completed Calan Concer completion of cause of death? this certificate hes Dementa 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Inpatient 2 DER/Outpatient 3 DOA funeral 27. Manner of Deeth 28d. Describe how injury occurred 28a. Date of injury (Month, Day Year) 28h Time of 28c. injury at Work? Certification: Director: After or Attending Neturai 5 Panding investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Spacify) 4 Homicide To the Hospital within 24 hours To the Funeral ( Certifying Physician: To the best of my knowledge, death occurred et tha time, dete and placa, and due to the cause(s) and menner as steted. Medical 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) Attending Physician

Agrey Healthcare

Baltmore 21229

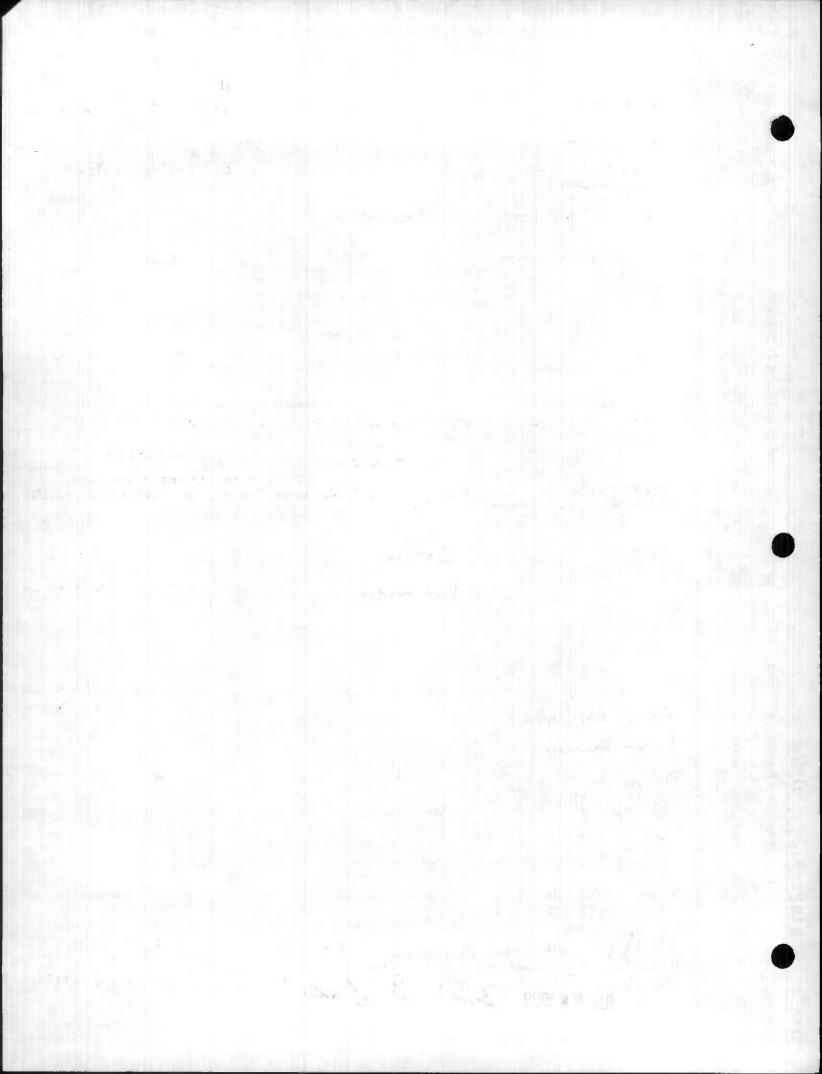
30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Selverman MD Mar 1999 32. Polymon Signature

State
Registrar

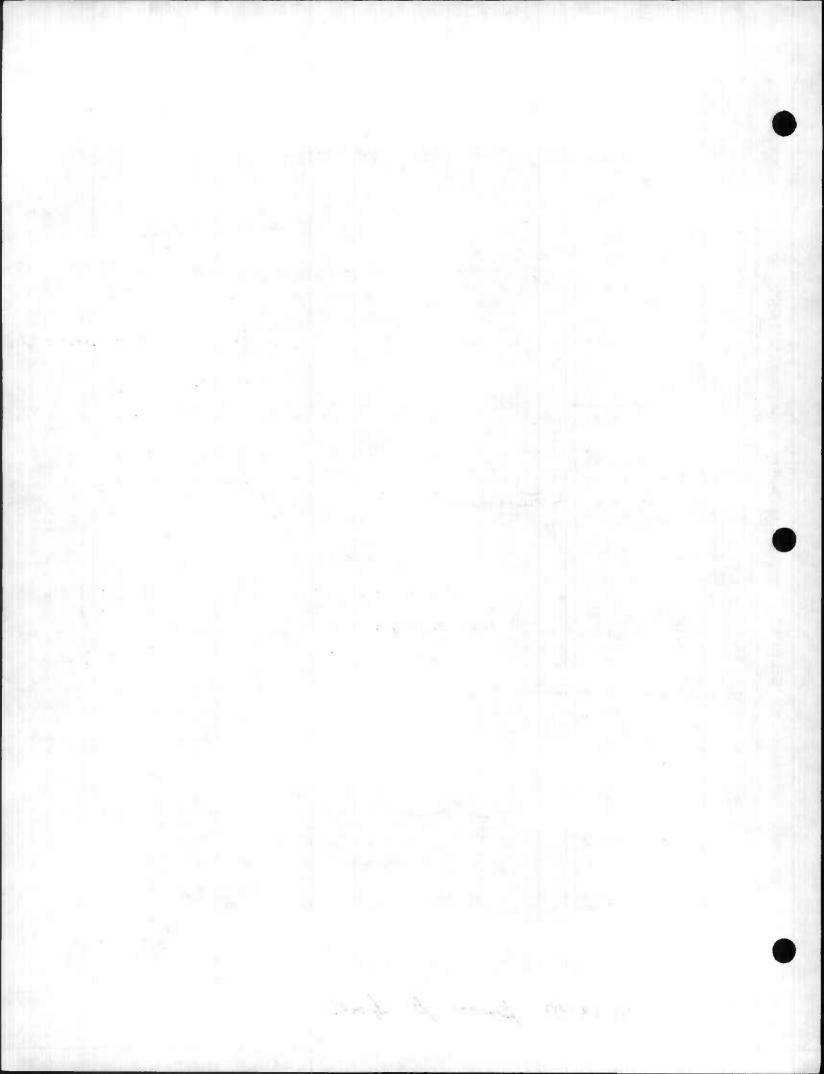
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NRYNE HA



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Detail Death

					Ce	rtifica	te of	Death		Reg. No.	1 21	450	
ysician	1. Decedent's Name (First, M Robert	iddle, Last) Head	1						2. Date of Do Month	Day 06	Year	3. Time of Death 8:56 PM	
edical miner	4a Facility Neme (If not institute UNIVERSITY O	ution, give stre	et and number		CAL CE	4b. City, Town, or Location of Death 4c. County of D						7.507.101	
l	5. Social Security Number 214–26–3329	6. Sex 1 [X] M	2 F 7. A	ge (In yrs.	last birthday 9 Yrs.		or 1 Year Days		(Month, D	th Year) 5, 1929	9. Birthplac Country Mary 1		
	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location											Inside City Limit	
Directo	MD Baltimore Catonsville  10e. Street and Number 10f. Zip Code									10g. Citizen of	What Country	1 ☐ Yes ZCNN	
al Di	1102 Lisadale		101.2	212	228		U.S.						
by Fune	11. Marital Status  1 □ Never Merried 2 ☑ N 3 □ Widowed 4 □ Divor	Merried	Wes Decedent Armed Forces 1 ∑Yes 2 ☐ If Yes, Give Year or Dates:	? No	rea 13.			Hispanic Origin? ( en, Mexican, Pus Specify:	Specify Yes <i>or</i> Norto Rican, etc.)	Bla	ce-American ck, White, etc y: White		
Completed	(Specify only his	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondery (0-12)  College (1-4or 5+ 4			(GM	dent's Us kind of w DO NOT TUCTI	ork done	usiness/Indus Enter					
o Be C	17. Father's Name (First, Midd George Franci						18. Mother's Name (First, Middle, Maiden Sumame) Alberta Mae Hatt						
2	19e. Informent's Neme/Releti	is (Stree	and Number or I	Bural Route Numi	er. City or Town	State, Zip Co	ode) 1 o MD21						
	Barbara Head  20e. Method of Disposition  1  Buriel 2  Cremative 4  Donation 5  Other	on 3 □Reme	ovel from Stete	20b. I	Place of Disp	osition (Na	ame of other pla		Date	20c. Location	- City or Town	, State	
	21. Signature of Funerel Serv	Funeral Homes, Inc. Catonsville, MD 21228											
fedical Examiner	Immediate Cause (Finel disease or condition resulting in death)  Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	Cy	Due to (c) Due to (c) Due to (c)	or as a conse or as a conse	quence of OPESS	): Preu ): [1871	monits			1/4	week  veek  year	
Physician/M	d. Kidney from plan to from  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part								23b. Did tobacco use contribute to the cause of dec				
by Phy	Hypertensi	Hypertension							10	3 Probel	oly 4 Unkno		
Completed	_ Y _ C _		-		performed? available			autopsy findings able prior to eletion of cause ath?					
	25. Was case referred to med	lical						26 Place of D	auth (Check only	Yes 2 ANO	101	′es 2□ No	
To Be	axaminer?	Hosp	oitel: 1 Inpati	ient 2	ER/Outpatie	nt 30 C	UA	her: 4 Nursing	Home 5□ Res	idence 6 🗆 Ot			
Certification:	27. Manner of Death  1  Natural								28d. Describe how injury occurred  28l. Location (Street and Number or Rural Route Number, City or Town, State)				
edical Cer			m: To the best	of my kno	wledge, dea			ime, date and plac opinion, death oc					
Me	29b. Signature and title of cer		0	50011		1		se number		29d. Date sign	1	y, Year)	
State	15mg D Bonkelt MD  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  BRET D. BORCHELT, MD 22 S. GREENE ST BALTIMUKE, MD 21201  31. Date filed (Month, Day, Year)  32. Registrar's Signature G. Lookh												



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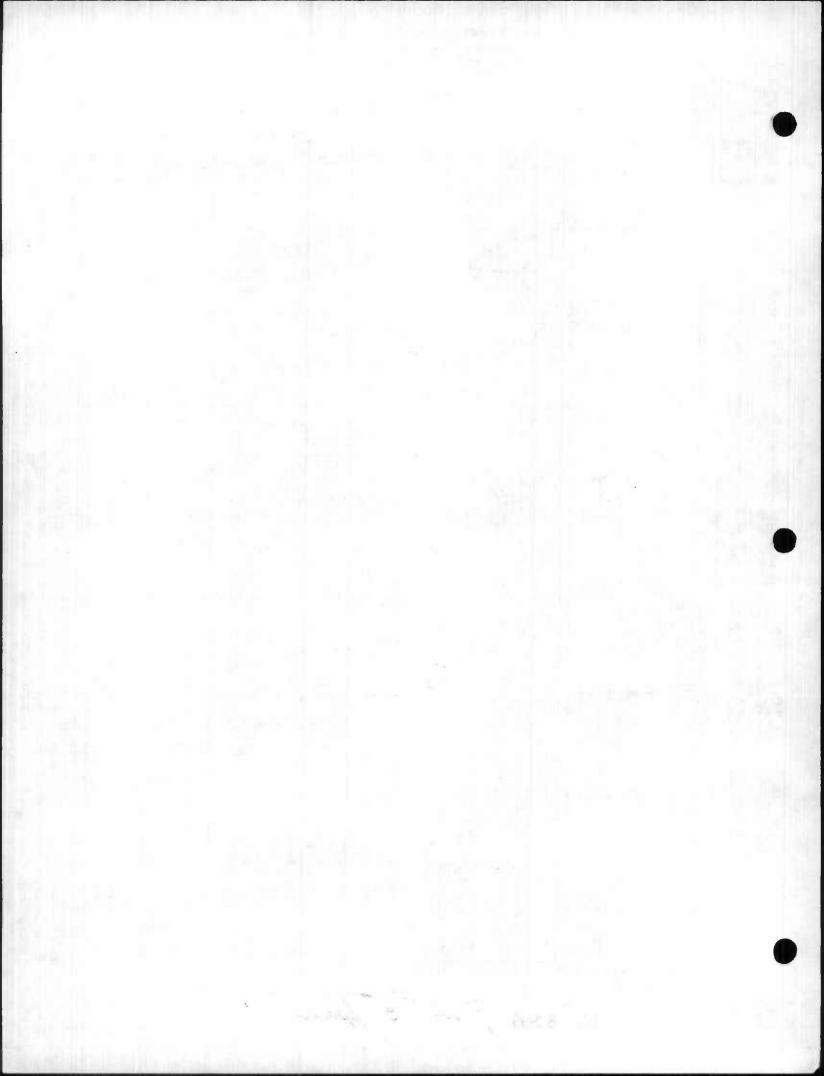
State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month FANNIE HERSKOWITZ 1, 1999 JULY 6:20 AM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 725 MT. WILSON LANE #325 BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1□M 2MF Hours 215-40-1820 92 Director JAN.17,1907 MD Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 ☐ Yes 2 No MD BALTIMORE Director BALTIMORE 25a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? õ 725 MT. WILSON LANE #325 21208 23a U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Berns 12. Was Decedent Ever in U,S Armed Forces? 14. Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married 1 Yes 2 No ò 1 ☐ Yes 2 No altimore, Maryland 21215-0020 Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced WHITE Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 filled within Elementary/Secondery (0-12) College (1-4or 5+) TEACHER BALTO. PUBLIC SCHOOLS 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental To HARRY REBECCA HERSKOWITZ WOLIZER 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) \* Department of Health a Important: if them 27 is any injury or other tree JOSEPH DEANE / NEPHEW 528 WOODWARD DRIVE - MADISON, WISCONSIN 53704 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, Steta cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/4/99 BETH TFILOH CEMETERY WOODLAWN, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 winer ie, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only ona ceuse on each line. 23a. Pert1. Enter the disees shock, or heart failure. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CONGESTIVE HEART FAILURE 2 YEARS **Examiner** Due to (or as a consequence of): Examiner bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical the Due to (or as e consequence of): 88 039 P.O. F Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ned by 1 Yes 2 No 3 Probably 4 Unknown RENAL INSUFFICIENCY Records. Sign by 24b. Were autopsy findings available prior to Be Completed page 2 ahould 24a. Wes an autopsy completion of cause of death? 1 ☐ Yes 2 X No 1 Tyes 2 No. certificate of Vital Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 8 Other (Specify) Certification: To 1 ☐ Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Division Hospital or Attending 1X Neturel 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funeral D completely filled pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical To the 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D38675 JULY 1, 1999 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) MESHULAM 1147 S. HANOVER STREET BALTIMORE, MD 21230

**DHMH 16 Rev 6/95** 

State Registrar 31. Date filed (Month, Day, Year)

32. Registrads Signature



Physician /Medical Examiner

Division of Vital Records, P.O.

Baitimore, Maryland 21215-0020

Examiner sician and buriel-transit The law requires that the death certificate be executed physician s the buriel Physician/Medical US0 23 signed b by Completed page 2 s or Attending Physicien: Be Certification: To this funeral After a after deeth.

**Physician** 

/Medical

Examiner

Director

Funeral

Completed

Be

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**Funeral** 

Director

the Maryland ahow

Pages 1 and 2 should be filed within 72 hours after deeth with the Maryle nent of Health and Mentel Hyglene.

ant: If item 27 ie marked other than "naturel", or items 23s or 28s-f ahov ury or other traumatic event, the Medical Examinar must be notified as

permit. Page Department of Important: If eny injury or page.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, Ierm, street, lactory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

31. Date filed (Month, Day, Year) JUL 08

30. Mame and address of person who completed cause of death (Item 23a) (Type, Print)

Douglas Clarke, M.D., FACC 32. Registrar's Signature

7505 Osler Drive Suite 214 Towson, MD 21204

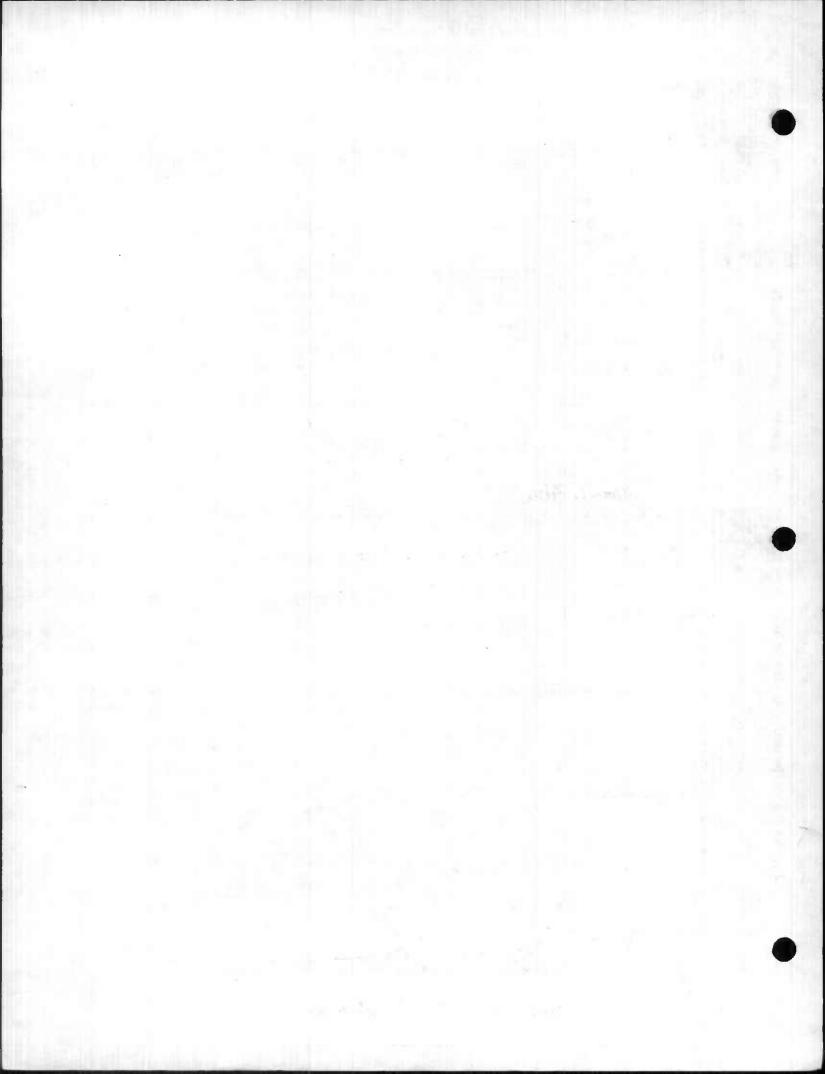
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July 6, 1999

**DHMH 16 Rev 6/95** 

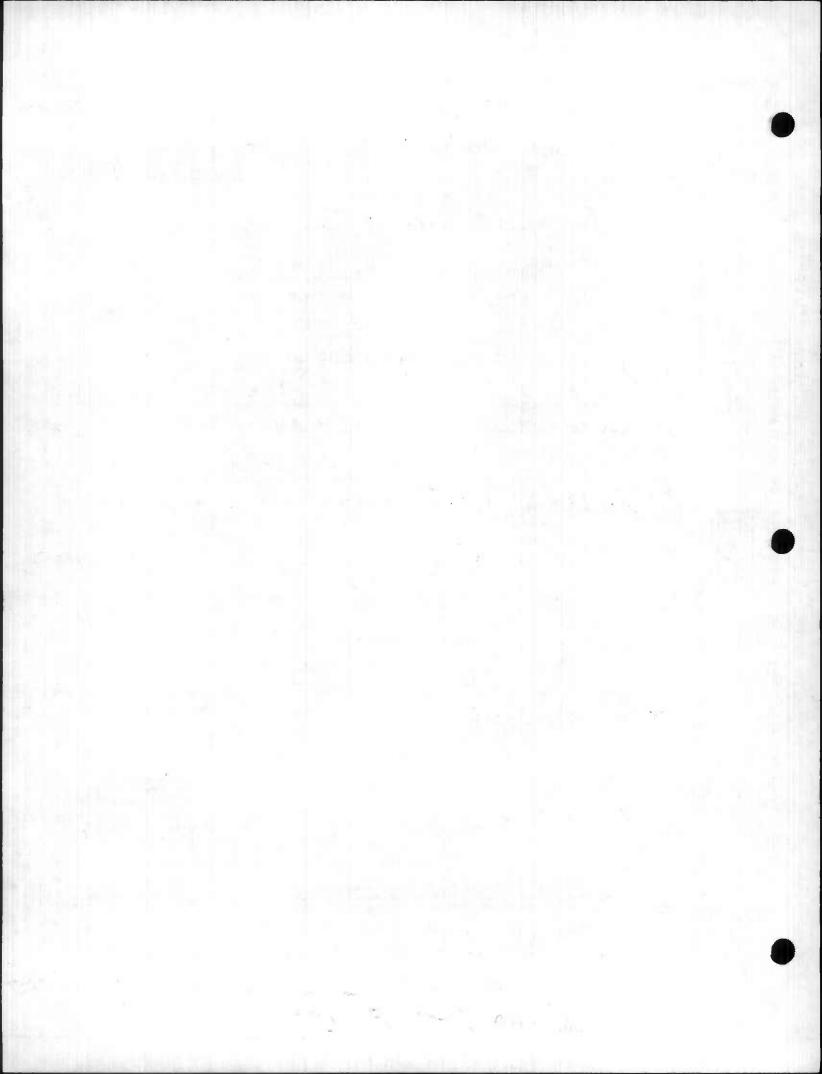
To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by

edical



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:300m /Medical 4s Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospital Cen 7. Age (In yrs. last birthday) Baltimore Rosedale ware If Under 24 Hrs. If Under 1 Year Security Number Birthplaca (State or Foreign Country) **Funeral** Months Deys 216-28-7195 Hours 10M 20 F Yrs. Director 10 Maryland Usuel Residence of Decedent 72 hours after death with the Maryland 10a. State ahow 10b. Counts 10c. City, Town or Location 10d. Inside City Limits Himore 1 Yes 2 No Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces?

1 (D/Yes 2 □ No If Yes, Give Yeer or Detes: Raca - American Indian, 11 Marital Status Black, White, etc. 1 Never Merried 2 Merried 1 Yes 25 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) mportant: If Itam 27 is marked other any injury or other traumatic event, if 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Illiam OROHIV 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 21236 20b. Piece of Disposition (Name of cemetery, crematory or other piece) altimore, 20e. Method of Disposition 20c. Location - City or Town, Stete 15 Buriel 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify) Valley **Separtment** 22. Neme and Address of Fecility EVANS 21. Signeture of Funeral Service Licenses Funeral Chapel Hartord 21234 23a. Part . Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Cancer Luna year Examiner Due to (or as e consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequença of): P.O. Box 68760. Physician/Medical Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 15 Yes 2 No Brain 3 Probably 4 Unknown Metastases Division of Vital Records. þ Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1□ Yes 2NNo 1 ☐ Yes 2 ☐ No certificate or Attending Physician: funeral director, 25. Wes case reterred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Suppatient 2 ER/Outpatient 3 DOA this Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Aftar 5 Pending investigation 1 Netural 1 TYes 2 No within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. 29a. Certifier (Check only one) ş 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 196568 30. Nema and address of parson who completed cause of death (Item 23a) (Type, Print) 9000 Franklia Square Drive Buttimore, Maryland 2037 Giron-32. Registrer's Signeture 31. Dale filed (Month, Day, Year) Registrar



# ATherine Jones B. Maryland 21215-0020

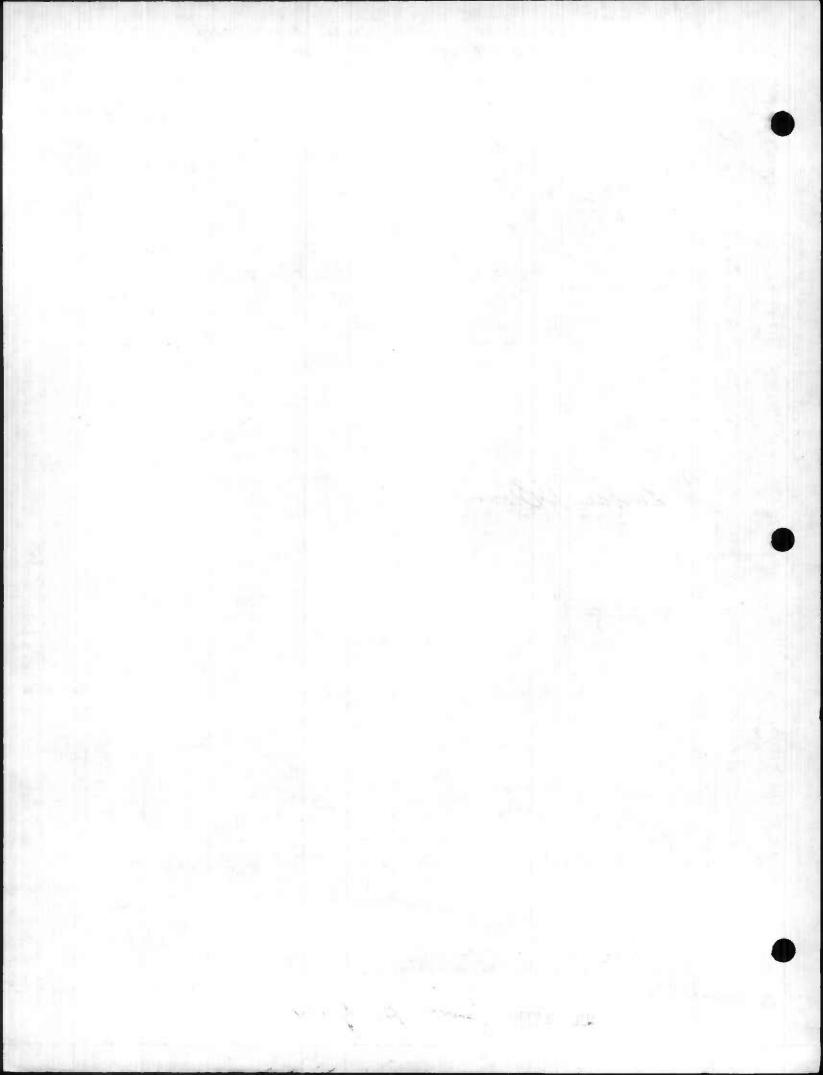
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** JONES CATHERINE Ju 1999 2:25 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BAITIMORE FRANKlin SPUARE DilAI ROSEDAJE H Under 24 Hrs. | 8, Dat Center 1705 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Days 74 Months Hours 218-22-7324 Director NOV 3 MARYLAND Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XXNo Director BALTIMORE CHASE 28a-f MARYLAND 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 9901 BERLINER PLACE APT I 21220 U.S.A. therms 23a 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yee, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Merried Specify: BLACK 'natural', or 1 Yes 2 XX Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOME PROVIDER DOMESTIC 7th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be and Mental MAXWELL JONES IDA PRESTON 19e. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nam 27 is Audrey M. Jones/Daughter 4804 HaMILTON Avenue, Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 8 important: If It any injury or o once. 12 Burial 2 Cremation 3 Removal from Stete HOLLY HILLS MEMORIAL 4 ☐ Donation 5 ☐ Other (Specify) 7-7-99 MIDDLE RIVER, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME PA urbara 1206 W NORTH AVENUE 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel · Chronic ObsTructive Pulmonary Disease disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examine physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. The law requires that the death certificate be Physician/Medical Due to (or as e consequence of): 90 987 P.O. 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to 24a. Was en eutopsy performed? Completed completion of cause of death? page 2 2 No 1 Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Dunpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Dey Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After 5 Pending 1 Yes 2 No Investigation death. 2 ☐ Accident hours after deat 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral Di completaly filled is edical ( Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier MD 199 96667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip SQUARE DR. BAITIMORE, MARYLAND 21237 FRANKlin DR Anila 9000 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

Registrar



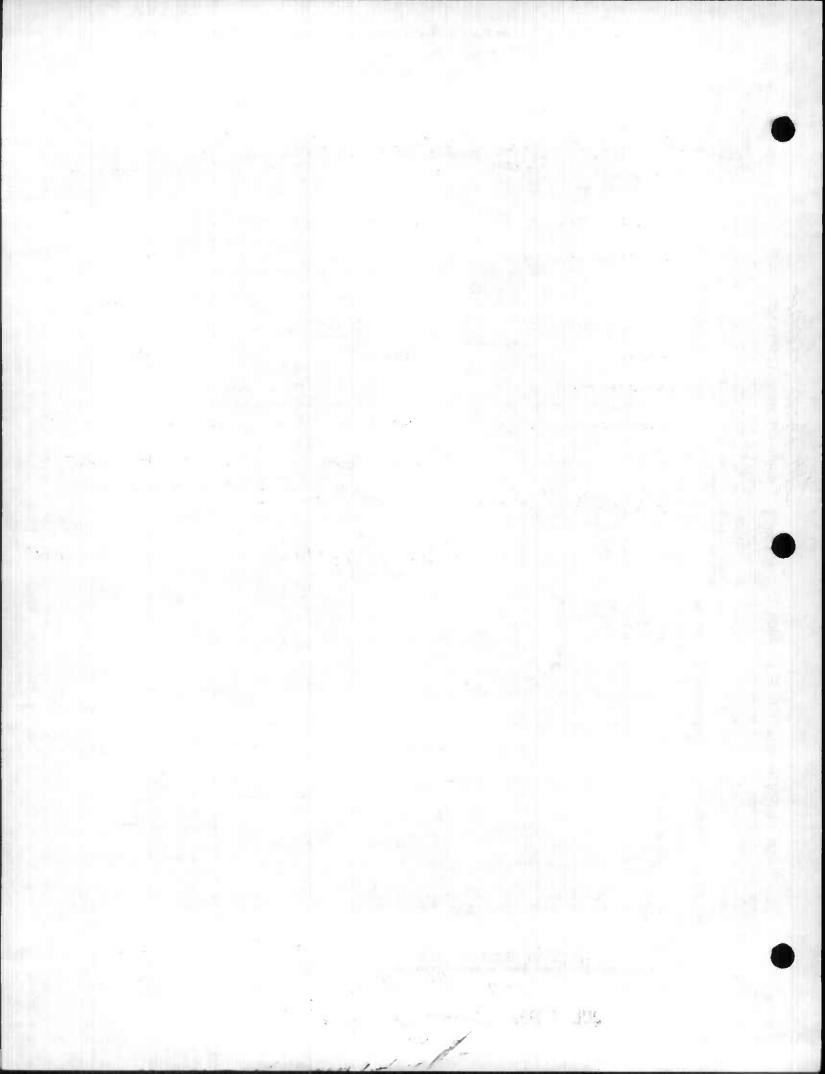
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Month Year **Physician** :55 AM JUI ANNA **JACKSON** /Medical 4b. City, Town, or Locailon of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner Rathmore Uly If Under 24 Hrs. 8. Date of Birth (Month), Day, Year) 105D1+GL MATUGAY eneral If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 10 M 20 F Months Yrs 86 MARYLAND **Director** 216-23-4496 AUG 10 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Nes 2 No Director MARYLAND N/A BALTIMORE CITY 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or itama 23a or Medical Examiner must be r 2353 DRUID HILL AVENUE 21217 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK à 3 Malidowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Eiamantary/Secondary (0-12) College (1-4or 5+) the unknown DOMESTIC PRIVATE 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother'a Name (First, Middla, Maidan Sumama) 89 f and 2 should be feath and Mental NATHANIEL MARTIN MARTIN ANNIE 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. informant's Name/Ralationship (Type, Print) Health: Eleanor Dunham/Daughter 1840 Division Street , Baltimore , Maryland 21217 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20a. Method of Disposition Date 20c. Locailon - City or Town, State Pages ent of 12 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT ZION CEMETERY 7/10 BALTIMORE, MARYLAND 21. Signature of Funeral Servica Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Physician Physician Immediate Causa (Final disease or condition resulting in death) /Medical UNKNOWN Examiner Dua to (or as a consequence of): Physician/Medical Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of) the death certificate be exec Box 68760. Due to (or as a consequence of): as I USB ed by the e P.O. Part ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records. by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy peen certificate hes page 1 ☐ Yes 2 ☐ No Division of Vital Physician: director Be 25. Was cese referred to medical 26. Piace of Death (Check only one) Hospital Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To After this funeral 27. Mannar of Death Date of injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred Hospital or Attending 24 hours after death. 1 Naturai 5 Pending Invastigation 1 Yes 2 No 2 Accident after death 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stata) Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) à 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledga, daath occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a, Certifiai To the Hosp within 24 hou To the Fune completely fil edical (Check only 29c. License number 29d. Daie signed (Month, Day, Year) 29b. Signature and title of certifier 12678 30. Nama and addrass of person who completed causa of daath (item 23a) (Type, Print)

State Registrar UR. James
31. Date filed (Month, Day, Year)

32. Registrar's Signature

8 1999



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q 56 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Johnson 01:30 05 1999 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Baltimore Johns Hopkins Bayview Medical Genter if Under 24 Hrs. Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) 1 □ M 2 □XF Months Davs Hours Min 51 Yrs 214-50-6389 OCT 3, 1947 MARYLAND Usual Residence of Decadant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2000 BALTIMORE CO **ESSEX** MARYLAND 10e. Street and Numbar 10f. Zip Code 10a. Citizen of Whet Country? II.S.A. 21221 1624 GAIL ROAD 13. Was Decedent of Hispenic Origin? (Specity Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ Mo If Yes, Give Year or Dates: 14. Race - American Indian, 11. Maritel Status Biack, White, etc. 1 Never Married 2 ☐ Married Specify: BLACK 1 ☐ Yes 2 X № Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Etementary/Secondary (0-12) College (1-4or 5+) SK 12 yrs vrs REPRESENTATIVE 18. Mothar's Nama (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) DOROTHY M. JOHNSON CLARENCE A JOHNSON 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Raletionship (Type, Print) Antainette Wiley/Neice 6807 Redrose Way, Baltimore, Maryland 21222 20b. Place of Disposition (Name of cemetary, cremetory or other place) 20c. Location · City or Town, State 20e. Mathod of Disposition Dete 1 ∑ Suriai 2 ☐ Cremation 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) HOLLY HILLS MEMORIAL 7-9-99 MIDDLE RIVER, MARYLAND 21. Signature of Funeral Service License 22 Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA war 1206 W NORTH AVENUE Approximata interval Between Onset end Deeth 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or haart failura. List only one ceuse on each line. Immediate Cause (Final years disease or condition resulting in death) or es e consequence of) Sequentially list conditions, if any, teading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated evants resulting in daath) Lest Due to (or es e consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 1 | Yes 2 | No 3 | Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 T Yes 2 No 1 Tyes 2 No 25. Was cese referred to medical 28. Place of Death (Check only one)

Physician /Medicai **Examiner** Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show

"natural", or items 23s or

7 is marked other than "natur traumatic event, the Medical

other 1

permit. Pagas Department of Important: If It any Injury or of pnce.

Directo

Funeral

by

Completed

Be

Pagas 1 and 2 should be filed within 72 hours aftar death with the Maryland nant of Haalth and Mental Hygiana. Int: If Itam 27 is marked other than "natural", or items 23s or 28s-f show

Baltimore, Maryland 21215-0020

The law requires that the death certificate be axecuted physician and tha burial-transit 88 attanding p for usa as signed by tha a d be detached f should should cartificata has t lirector, paga 2 s director,

To this funaral Aftar

Physician/Medicai

by

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Certification:

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Division of Vital Records, P.O. Box 68760, or Attending Physicien: aftar daath. Director: Aft n 24 hours after dag ne Funeral Director niataly filled in by th Hospital

To the Hosp within 24 ho To the Fune complately fi

1 Tyes 2 No

27. Manner of Deeth

1 Maturel

2 ☐ Accident

3 ☐ Sulcide

29a. Cartifiar

4 | Homicide

(Check only one)

29b. Signature and title of certifier

29c. License number

29d. Dete signed (Month, Day, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred

30. Nama and eddress of person who completed ceuse of daeth (Item 23a) (Type, Print)

Hospital:

28e. Date of Injury (Month, Day Year)

BALTIMORE MARYLAND 21224 PORTER MID VICTORIA 4940 EASTERN 31. Dete filed (Month, Day, Year)

28c. Injury et Work?

15 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated.

1 Tes

2 No

State Registrar

8 1999

5 Pending

investigation

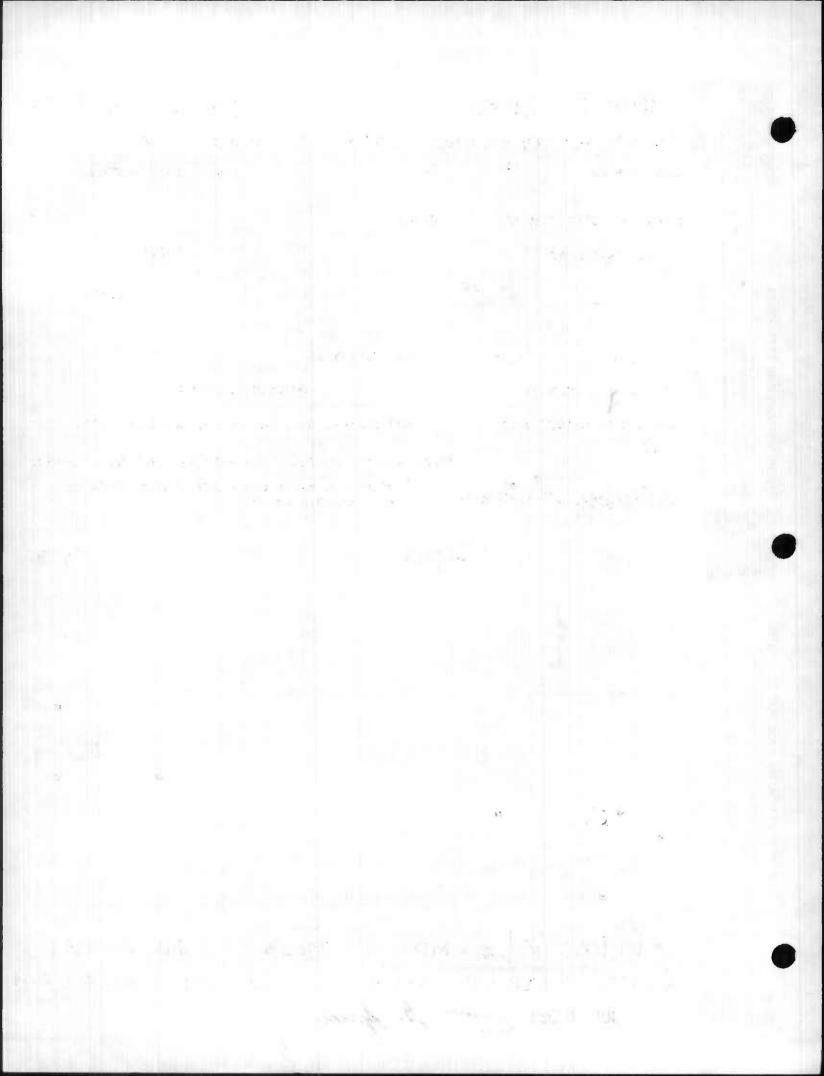
6 Could not be determined

32. Registrar's Signeture

1 Sinpatient 2 □ ER/Outpatient 3 □ DOA

28e. Place of injury - At homa, farm, straet, factory, office building, etc. (Specify)

28b. Time of



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Q 21457 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death **Physician** 30 JUNE Kenneth Francis King /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES LAUREL REGIONAL HOSPITAL LAUKEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Social Sacurity Number 7. Aga (In yrs. lest birthday) Birthplaca (Stete or Foreign Country) **Funeral** Months Days Hours Min XXM 2□ F 61 Yrs. Director Dec.11, 1937 England 049-46-2739 Usual Residence of Decedent ahow 10a State 10b County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yes 2 X No Directo Maryland Prince George Laurel 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? Frammer must be 9105 Tumbleweed Run 20723 USA Apt. J Funeral 12. Was Decedent Ever In U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yea or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Black, White, etc. 1 Nevar Married 2 Married Ì ☐ Yas 2 ☐ No It Yes, Give Yeer or Dates: "natural", or White 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced should be filed within 72 hou and Mental Hygiane. • merked other than "natura turnatic event, tre Monical E Completed 15. Decedent's Education (Specify only highast grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Electronic Engineer Aerospace permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is merked other any injury or other traumatic event, page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Francis Crowhurst King Dora Jenkins 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Yvonne Christine King/Wife 9105 Tumbleweed Run Apt J., Laurel, Maryland 20723 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Spacify) Baltimore Washington Cr. 7/2/99 Laurel, Maryland 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility Fleck Funeral Home, Inc. amure 7601 Sandy Spring Road, Laurel, Maryland 20707 e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, that are the control of the cause on each line. 23a. Part1. Entire Approximate interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final · ARTERIOSCUEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in deeth) Examiner Due to (or as a consequence ot) Examiner physician end s the burial-transit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of) Physician/Medical Due to (or as a consequenca of): for use as signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ should t 24a. Was an autopsy performed? 24b. Were autopsy tindings available prior to Completed completion of cause of death? s cartificata has b director, pege 2 s 2 No 1 ☐ Yes 2 ☐ No director, 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA 2 1 ☐ Inpatient 2 ☐ ER/Outpatient this 28a. Date of Injury (Month, Dey Year) 27. Manper of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending 1 Yes 2 No death. hin 24 hours after death. the Funeral Director: A npletely filled in by the fi investigation 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as ataled.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner, stated. 29e. Certifier edical (Check only one) Within 2 29d. Date signed (Month, Day, Year) 29b. Signature 0 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) MD 3001 HOSPITAL DRIVE MARIO

DHMH 16 Rev 6/95

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72 hours after death

altimore, Maryland 21215-0020

thet tha death certificate be executed

law requires

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Box 68760

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Records,

Division of Vital or Attending Physician:

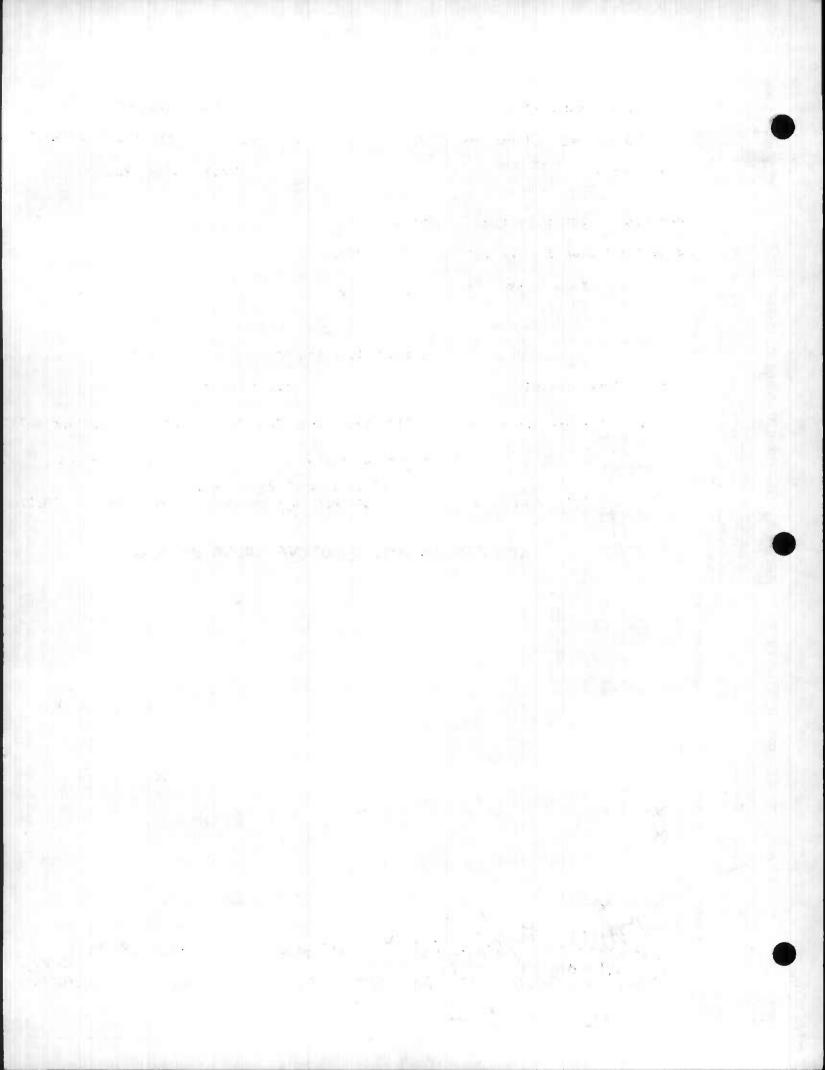
81999

31. Date filed (Month, Dey, Year)

32. Registrar's Signature

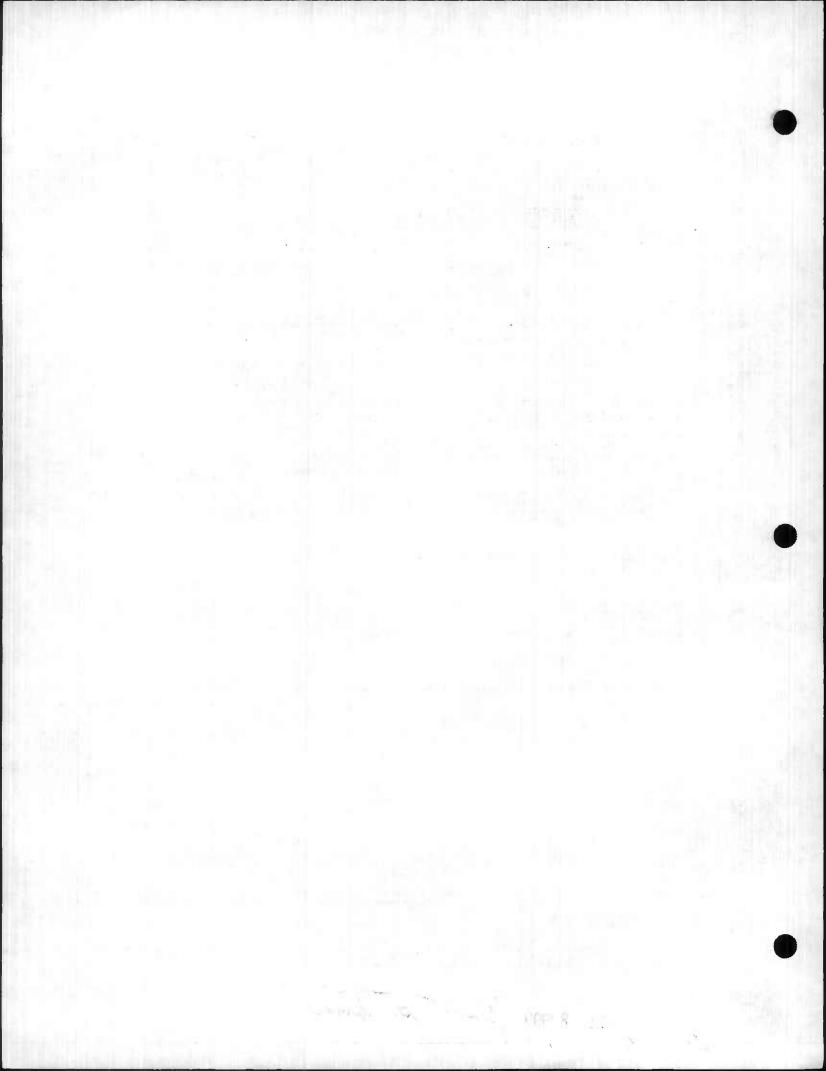
Registrar

State



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				C	ertificate o	f Death		Reg. No.	99	21458	
	Decedent's Nama (First, Middle, Last)					2. Data of Do	eath Day	Year	3. Tima of Death		
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	Name (If not institution, gi	ve street and number)	)			4b. City, Town,	or Location of Deat	h 4c. County	of Death		
	ISH CONVALES					BALTIMO		BALTI			
113-	28-8247	Sex 1□ M 2(X) F	ge (In yrs. la 98	yrs.	Months Day		frs. 8. Data of Bi (Month, Di FEB. 1	ay, Year)	9. Birthpla Countr	ice (State or Foreigr y) GERMAN	
10a. Stata	dence of Decedent  10b. County		10c. City,	Town or	Location		DI COLOR		100	d. Inside City Limits	
MD etc	BALTI	MORE	BALT							1 ☐ Yas 2 No	
1 12.0	1320 CCCTTC DDVDD ICDD							U.S.A		y?	
3 XXWid	Status rer Married 2 Married lowed 4 Divorced	12. Was Decedent Armed Forces? 1  Yes 2  R Yes, Give Year or Dates:	?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Maxican, Pu			(Specify Yas or No arto Rican, atc.)	5 Specify	tace - Amarican Indian, Black, Whita, atc. City: WHITE		
Elementa	15. Decedent's E (Specify only highest go			16a. De (Gi	cedent's Usual Occ va kind of work dor DO NOT use reti	cupation na during most of	working	16b. Kind of B	usinass/Indu	istry	
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	Name (First, Middle, Las	e)			TAILL	18 Mother's I	Nama (First, Middle				
n 17. Fathers	JOSEP		1	HELL	MANINI	JEANET			ASSER	MAN	
-	ant's Name/Relationship		- i				Rural Routa Numb				
	A HAMEROFF /						#6 - BAL				
20a. Metho	d of Disposition		20b. Pla	ce of Dis	position (Nama of		Data	20c. Location -			
	rial 2 ☐ Cremation 3 nation, 5 ☐ Other (Spec			cemetary, crematory or other place) EDAR PARK CEMETERY					9 PARAMUS, NJ		
	re Funeral Service Lice				22. Nama and Add		1.				
1	SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD - PIKESVILLE,										
23a. Part1	Enter the disease, or cor, or heart failure. List only	nplications that caused	d the death.	7						Approximata ntarvat Batween	
Sequential if any, lead cause. (Dis that initiate resulting in	Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):  Due to (or as a consequence of):										
Clary	r significant conditions	d	out not result	ting in the	underlying cause	tiven in Part I	23b. Did	tohacco una co	otribute to 1	the cause of death	
								1 Yea 2 No 3 Probably 4 Unknow			
Completed by								performed? available prid		plation of causa	
							10	Yas 2 No	10	Yas 2□ No	
	sa refarred to medical					26. Placa of	Death (Check only	ona)			
O 1 Yes		Hospital: 1 ☐ Inpatie	ent 2 E	R/Outpat	ient 3 DOA	Other: 48 Vursin	g Homa 5 ☐ Ras	idence 6 □Oth	ner (Specify)		
27. Manner 1 Nat 2 Acc 3 Sui 4 Ho	ural 5 Pending investigation		ly Year)	28b. Time Injun	/ W	jury at vork? □ Yas 2 □ No	28d. Describe	e how injury occurred			
3 □ Sui 4 □ Ho		jury - At hom ic. (Specify)					cation (Street and Number or Rural Route Number, or Town, Stata)				
29a. Certific (Check one)	or 1 KCertifying Pronly 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sto	f axaminatio	ledge, de on and/or	ath occurred at tha invastigation, in my	tima, data and play y opinion, daath o	ace, and dua to the ccurred at the time	causa(s) and m	annar as sta and dua to t	ited. tha causa(s)	
DAMP .	ure and title of certifier	este mentral su	arou.		29c. Lice	nse number		29d. Data signe	d (Month, D	lay, Year)	
1	Rammer Mr.	lle MD			2	47683		7/4	199		
30. Name a	nd address of person who		death (Item 2	23a) (Typ				, , ,	, /		
Raymon	00.01	Main Street	Sint	20	0	chown M	0				
te 31. Data file	d (Month, Day, Year)	32. Registr	rar's Signatu	10	-				10		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ANNIE KEE JULY 1999 1210 PM 06 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner JUHNS HOPKINS CENTE BALTIMORE MEDICAL TEK If Under 1 Year BAYVIEW If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 M 2 XX Director 216-32-1460 85 Jan. 9,1914 ENGLAND **Usual Residence of Decedent** the Manyland 10a. State 10b. County 10c. City, Town or Location r than "naturel", or items 23a or 28a-f ahow the Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 502 S. MONTFORD AVENUE 21224 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2/DNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours effer. Hygiene. Wher then "naturel", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes XXNo Specify: à 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Department of Health and Mentel Hygies
Important: if Item 27 is marked other ti
eny injury or other treumatic event, the DOMESTIC 8 HOUSEWIFE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN A. ELDER GODDARD ADA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 S. MONTFORD AVENUE, BALTIMORE, MD. FRANK W. KEEL/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SACRED HEART OF JESUS 7/9/99 BALTIMORE, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. 21231 Approximate Interval Between Onset and Death **Physician** /Medical tmmediate Cause (Final SEPSIS disease or condition resulting in death) hours Examiner Due to (or as a consequence of) physician end s the burial-transit requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): P.O. ed by the Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records. by should Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 212 No certificata Division of Vital Attending Physician: 25. Was case referred to medical 8 26. Place of Death (Check only one) Hospitat 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this After thi 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 1 PNatural 5 Pending investigation or Attending after death. Director: Aft d in by the fur 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 29a. Certifier edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES-000 UD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MALCUS BROWN M.D BALTIMORE, MARYLANO 21287 TOWER 110 600 N. WOLFE ST 31. Date filed (Month, Day, Year)

AHB

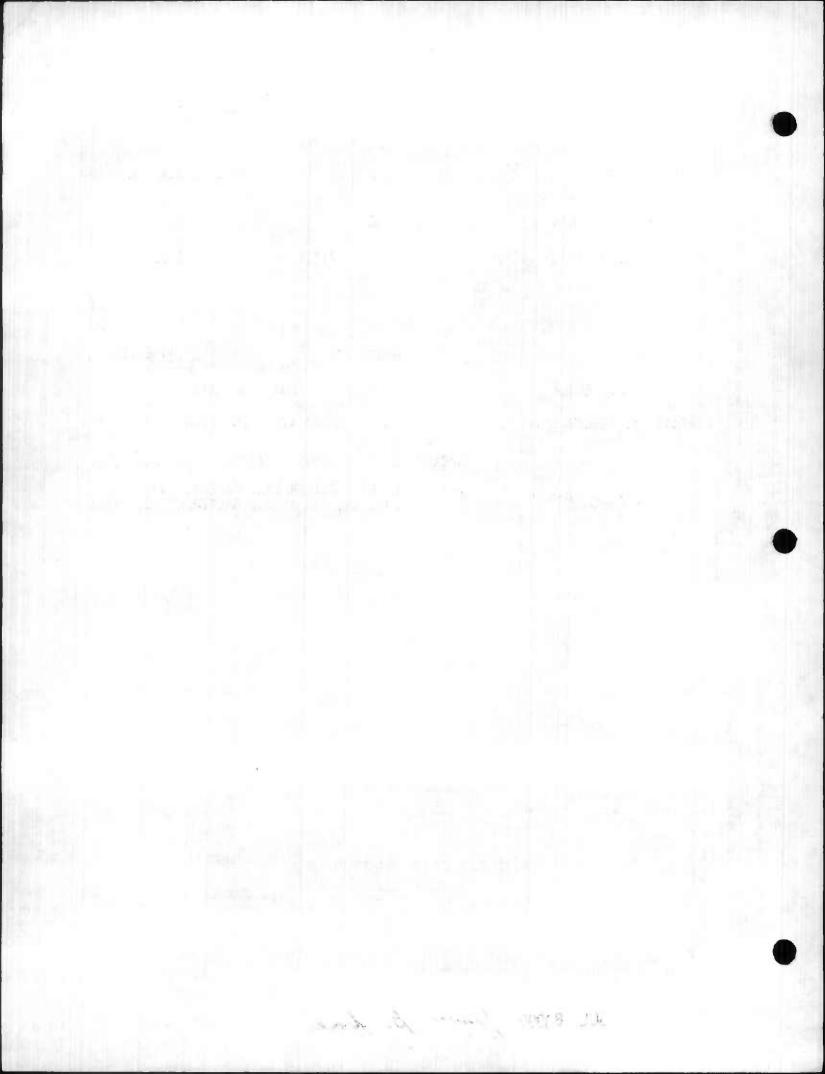
DHMH 16 Rev 6/95

State Registrar

JUL 8 1999

32. Registrar's Signature

A. Spark

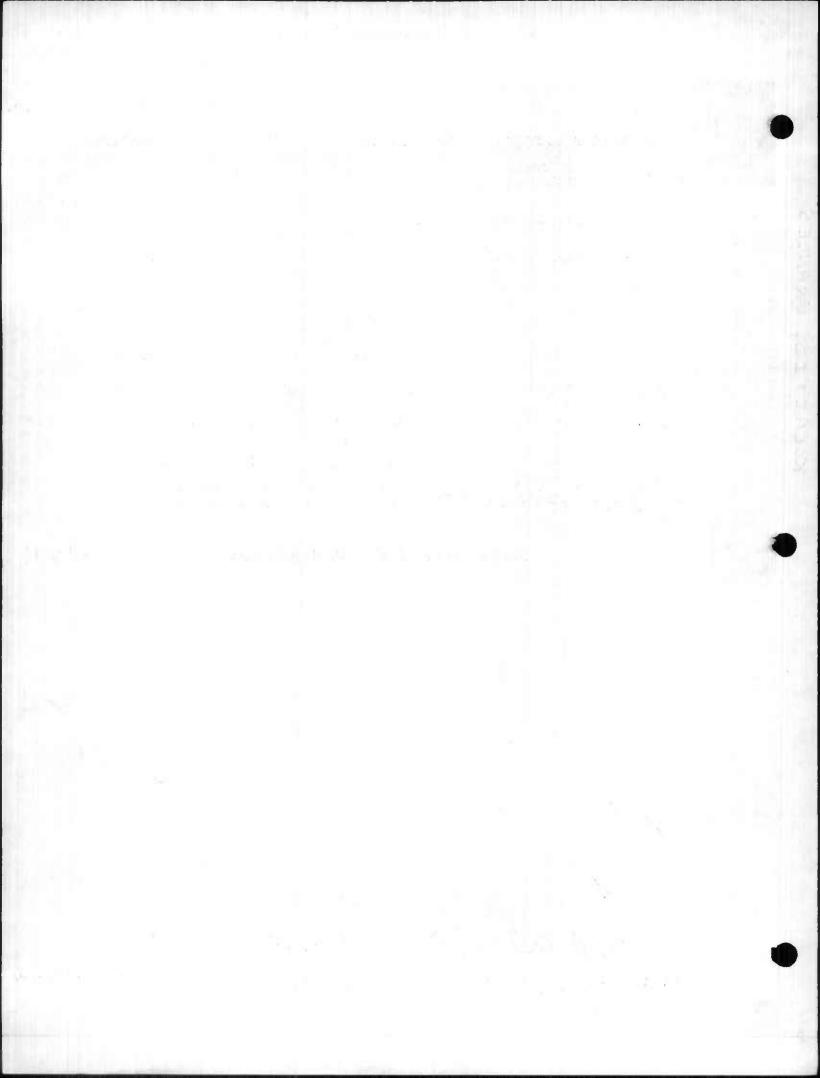


#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q

21460

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4	Physic /Medi		FRANCES	LANE	KOI	LAITIS			JULY	06 1	999	9:30	$A \cdot M$
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Maryland	N 0 0 0		19a. Informant's Name/Ralationshi						r or Rural Routa Numi		, Stata, Zip	Code)	
			Mr. David Bielaw	ski/son				Rd. Ri	dge, MD. 2	0680			
ore	Pages 1 nent of Hant int: If item		20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation	3 DRamoval from Si	0.0	ace of Dispo matary, crar	sition (Nama of natory or othar pla	ice)	Data	20c. Location	- City or To	wn, Stata	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Charles M. Lvkes July 1999 7:30 PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1018 Dalton Ave Baltimore Berkshire If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Days Months 1⊠M 2□ F 219-28-3528 66 July 18 1932 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 No Baltimore Berkshire 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1018 Dalton Ave 21224 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Ves 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Foreman Beth - Steel 12 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles M. Lykes Helen Rymer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Alice Jo-Ann Lykes /wife 1018 Dalton Ave Baltimore, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) July 12 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 1999 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. I st only one cause on each line. to not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) MULTIPLE MYECOMA 3 4RJ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lasl Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 70 3 Probably 4 ☐ Unknown 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 SNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

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Physician

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**Funeral** 

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permit. Page Department of Important: If any injury or

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Baitimore, Maryland 21215-0020

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Records, P.O. Division of Vital n 24 hours efter death.

Ne Funeral Director: After olesely filled in by the fun within 2

**DHMH 16 Rev 6/95** 

31. Date filed (Month, Day, Year) State Registrar

GARY COULT, MP

29b. Signature and litle of certifier

4 Homicide

29a. Certifier (Check only one)

32. Registrar's Signature

6569

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sporks

28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)

N. MANGET

**ORIGINAL** 

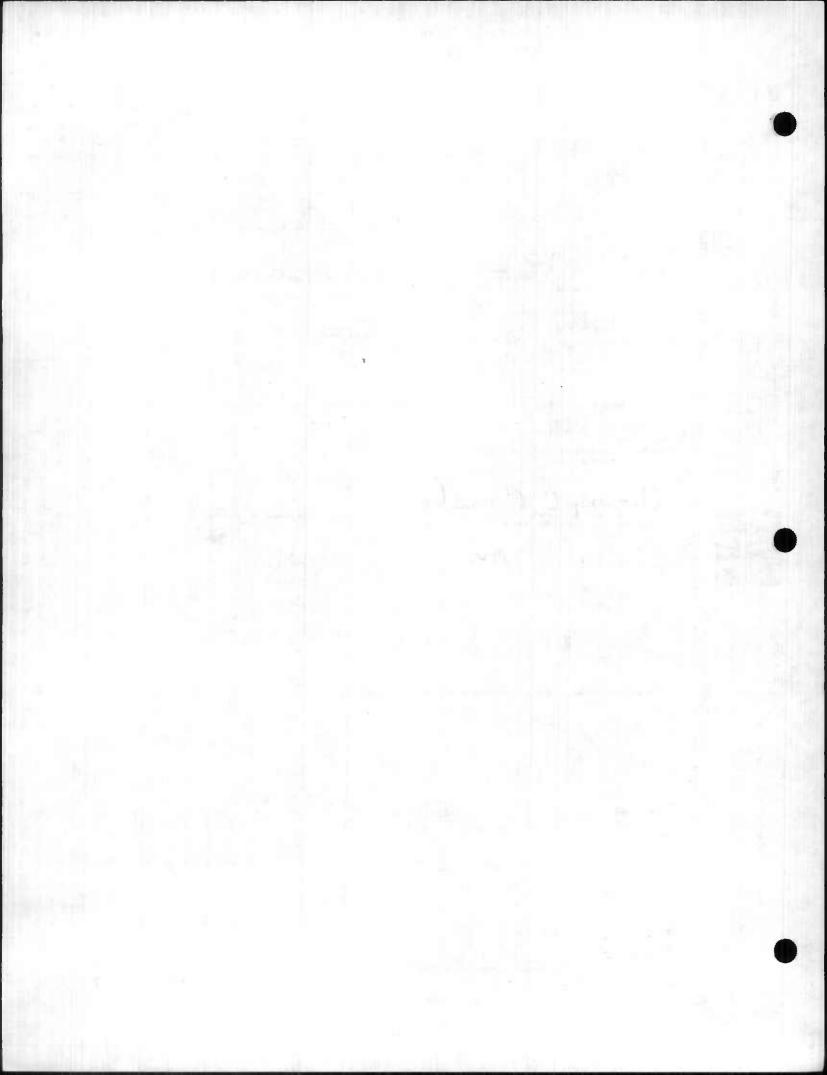
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

027730

ST. BALTIMONE MO

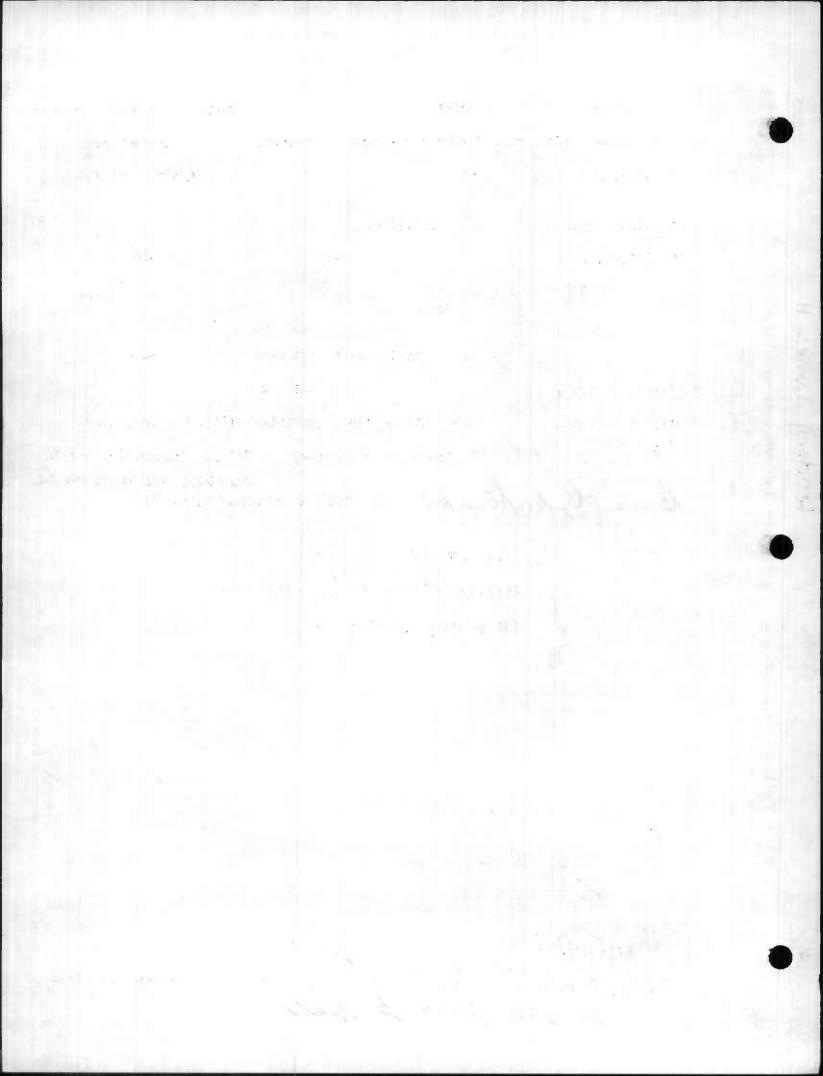
29d. Date signed (Month, Dey, Year)



			C	certificate o	f Death	34	Reg. No.		1402
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Physician /Medical	JAMES HAF	RVEY LIND	SAY			July	-	1999	10:28a
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by	3 ☐ Widowed 4 ☐ Divorcad	XXYes 2 □ No If Yes, Give Yeer or Dates:	43-46	1 ☐ Yes XX N	lo Specify:		Specif	v: Whi	te
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2	Peter Lindsay				Jeanne		(u	ınknow	m)
	9a. Informant's Name/Relationship (				et and Number or Ru				
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20	Da. Mathod of Disposition 1 M Burial 2 ☐ Cremation 3 ☐	Florence I from Chato	20b. Plece of D cemetery,	isposition (Name of crematory or other p		Date	20c. Location		
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2	1. Spnature of Funaral Service Licen	500 N		22. Name end Add	dress of Facility M	itchell-Wi	edefeld F	uneral	Home Inc.
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2	23a. Part1. Enter the disaase or com shock, or heart failure. List only	olications that caused	the deeth. Do not					T	Approximete Intervel Between
ian	Shock, of fleat failure. List only								Onset and Death
d	mmediata Cause (Final isease or condition	Acus	tole.						
er r	asulting in death)		Dua to (or as a co	nsaquence of):					
iner		, Acut	e Myo	cartial	in farct	400			
Examiner	equentially list conditions,	U	Due to (or as a cor	nsequence of):	infarct				
	dequentially list conditions, any, leading to immediata euse. Enter Underlying ause (Disease or injury	Covon	any o	rtem	disease	_			
S 1	nat initiated events esulting in death) Last	C	Due to (or as a cor	sequence of					
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Physic	art It. Other significant conditions of	ontributing to death bu	t not resulting in th	ne underlying ceuse	given In Part I.				the cause of death
						10	Yes 2□ No	3 Prot	bably 4 Unknow
leted by						24a Was	an autopsy	24b. We	ere eutopsy findings
ete						perfo	rmed?	col	elleble prior to mpletion of ceuse
Completed							1		daath?
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g m	5. Was cese referred to medicel examiner?	Hospital:			26. Place of Dea				
	1 ☐ Yas 2 Ø No 7. Manper of Death	1 🖾 Inpatier		MINITED DON	4 La ladialist t	lome 5 Resi	dence 6 LIOth how injury occur		γ)
0	1 Natural 5 Panding	28a. Data of Injury (Month, Day	Year) Inju		njury at Vork? Yes 2 No		,,		
tifical	3 Suicide 6 Could not be		ry - At home, farm			28f. Location (	Street and Num	ber or Rura	I Route Number,
Te	4 Homicide	building, afc.	(Specify)	, street, factory, offic		City or To	wn, State)		
	9a, Certifier 1 Certifying Ph	ysician: To the best of	f my knowledge, o	eath occurred at the	time, date and place	, and due to the	ceusa(s) and m	anner as s	tated.
edical	(Check only 2 Medical Examone)	niner: On the basis of and manner stat	examination and/o	or Investigation, In m	y opinion, death occu	rred at the time,	date and place,	and due to	the ceuse(s)
₹ 25	9b. Signature and title of cartifier			29c. Lice	ense number		29d. Date signe	ed, (Month,	Day, Year)
	May agui	Can O		1	20488		71	15/9	9
2/	D. Name and address of person who	completed cause of de	ath (Itam 92a) /T-	ma Print)				-1-	1
30	Sides Cattle		6569 N	Charles	57- #6	00 10	altimore	· mo	21204
State 3	1. Date filed (Month, Day, Year)		r's Signatura	4 1		-0			•
State	JUL 08	1999 32. Registra	neva	В. Др.	als				
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DHMH 16 Rev 6/95

Landsay, James

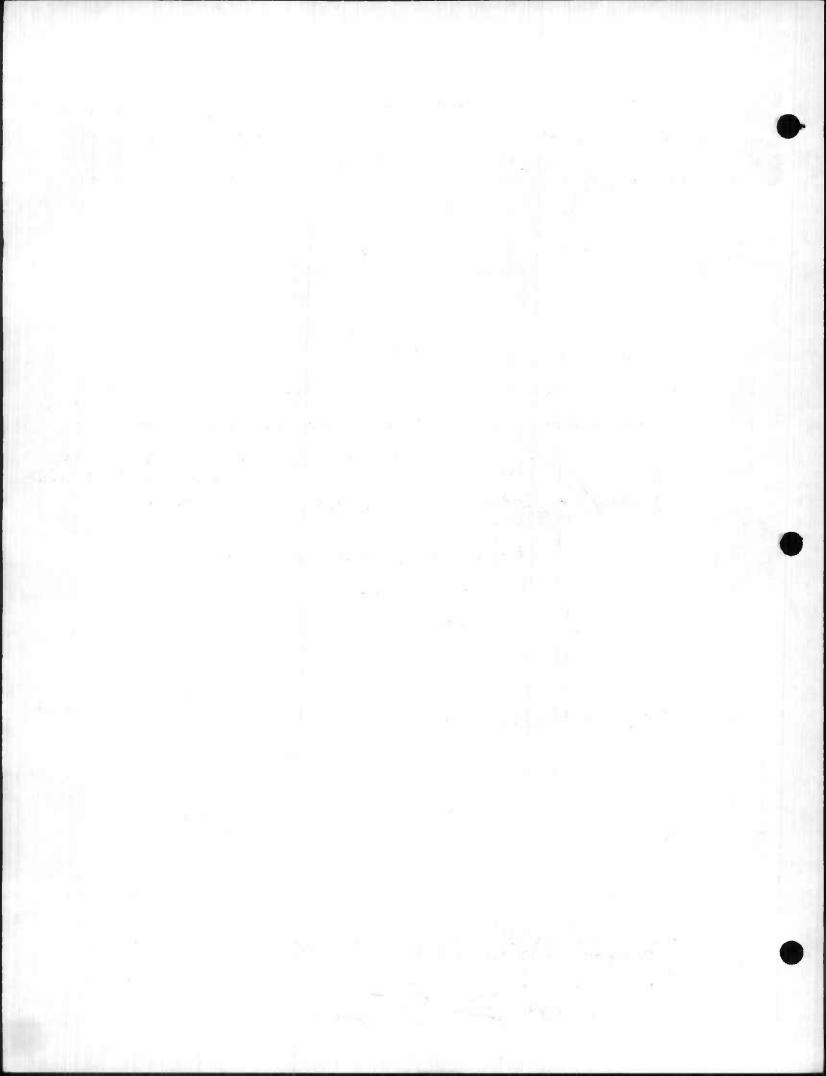


#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Cynthia Mitchell 99 16:21pm 03, July /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore NA Union Memorial Hospital 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, 03-19 Birthplece (Stete or Foreign Country) **Funeral** Months Days Hours 1 M X F 66 Yrs. Director 219-30-1325 Usuel Residence of Decedent MD the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Peges 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. Interfer 21 is merked other than "natural", or items 23a or 28e-1 show ury or other traumatic event, it is to write the most interfer and it is the most interference of the most interference or other traumatic event, it is the most interference or other traumatic event, it is the most interference or other traumatic event, it is the most interference or other traumatic event. MD NA Baltimore Director 1X Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 428 Whitridge Avenue 21218 USA Completed by Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black 3√ Widowed 4 Divorced 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Cook Company 12th Grade Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Alfred P. Wilson Florence Lemmon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 2 1 2 1 3 19e. Informent's Neme/Reletionship (Type, Print) Alonzo Mitchell 3418 Cliftmont Avenue Baltimore, Maryland 20b. Pleca of Disposition (Neme of cemetery, crematory or other piece) 20a, Method of Disposition 20c. Location - City or Town, Stete **X**☐ Burlel 2 ☐ Cremetion 3 ☐ Removal from Stete permit. Pege Depertment of Important: If any Injury or once. Zion Cemetery 07-08-99 Lansdowne, MD TEDonation 5 ☐Other (Speci Pre of Funeral Service I 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E, North Avenue Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Final Myocond disease or condition resulting in deeth) Examiner Due to (or es e consequence of). Examiner 10 The lew requires that the deeth certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that Initiated events resulting In deeth) Lest buriel-tren Due to (or es a consequence of P.O. Box 68760. Perfeusin Due to (or es e consequenca of): Physician/Medical the 98 use Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? sate hes been signed by page 2 should be detect 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 N Unknown Records. by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No certificate Division of Vital Hospital or Attending Physician: funerel director, 25. Wes case referred to medical Be 26. Place of Death (Check only one) ER- Union Mem. Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 X ER/Outpetient 3 ☐ DOA this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After 1 Neturel 2 Accident 5 Pending investigation s efter death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Placa of tnjury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital or within 24 hours of To the Funeral D completely filled? The Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) end menner stated. 29a. Certifier Medical 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) 3028 Green mount ave. 31. Dete filed (Mooth, Day, Year) Me 32. Registrar's Signeter State 8 199 Registrar



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent'e Neme (First, Middle, Last) 2. Date of Death Alma E. Maurer **Physician** VIL /Medical 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner Bel air Hartord Mariner Health If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1□ M 200 89 Yrs 184-12-4481 October 23, 909 Pennsylvania Director Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show treumstic event, me Medical Examiner must be notified at 1 ☐ Yes 2 No Hartord MD Directo Bel Olir 10e. Street and Number 10f. Zip Code 10g. Cifizen of What Country? Road U.S.A 21014 Meadow 213 Funeral 72 hours efter death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Maritel Stetus Black, White, etc. 1 Never Married 2 Married "naturef", or [ 1 Yes 2 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) illed within 7 I Hygiene. d 2 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n Wilton Hershey Elementary/Secondary (0-12) College (1-4or 5+) Houseparent School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Romberg William Della Kreiser 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an Belair, MD 21014 213 Meadow Rd. Jackie Maurer 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State important: If No. Triye 1 Buriel 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Crandrien Lack Annville, PA 22. Name and Address of Facility Chapel-Belair, P. A. Evans Foreral Chapel-Belair, P. A. Newport Dave orest Mill, MD 21050 21. Signature of Funeral Seglice License 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical . SEPSIS Immediate Ceuse (Finel WEEK disease or condition resulting in deeth) **Examiner** Due to (or as a consequence of) Examiner INFECTION IRINARY TRACT attending physician and for usa es the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest DIABETES MELLITUS Physician/Medical Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? ed by the a Pert if. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yes 2 No 3 Probably 4 Unknown signed by DEMEN þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy performed? 2 1 No Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate h 1∏ Yes 1 Tyes 2 No Division of Vital funeral director, Be 25. Was cese referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Mennet of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, olfice building, etc. (Specify) filled in by 4 - Homicide 29a. Certifier 11 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated. Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examinetion and/or Investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end menner steted. 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifie 29c. License number

2 NORTH AVE

32. Registrar's Signeture

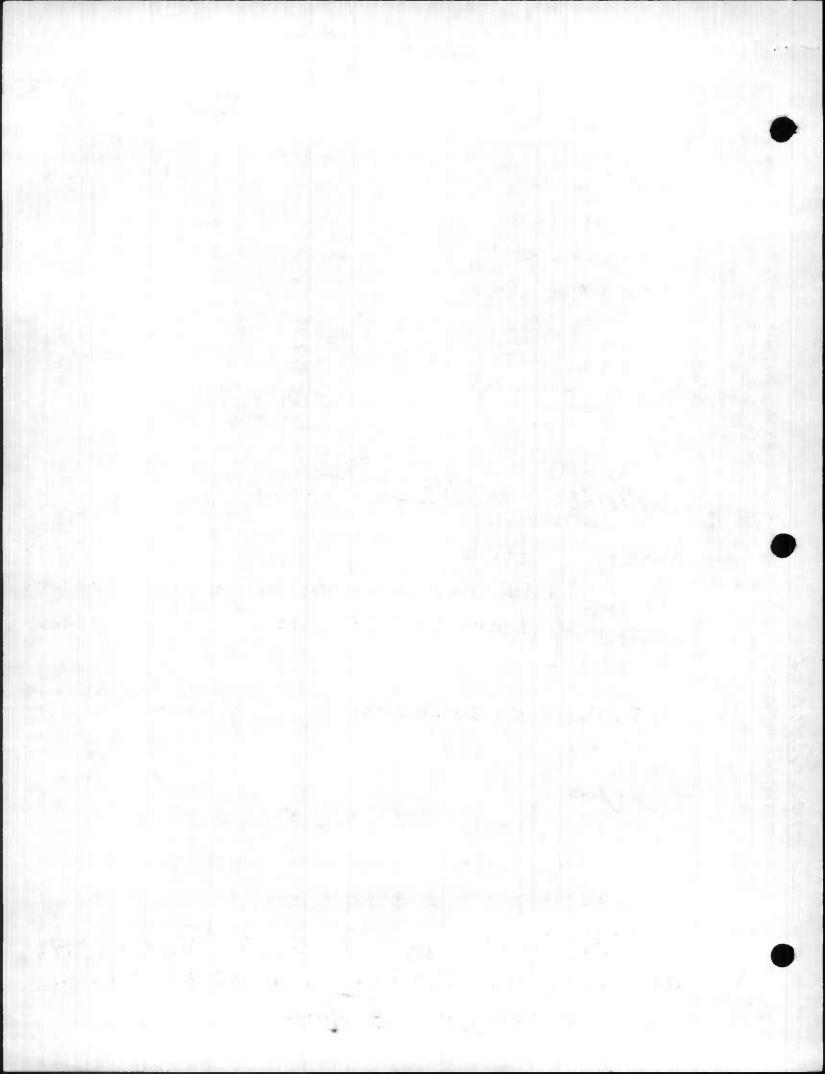
STE 101 BEZ AIR MD 21014

State Registrar

30. Name end address of person who contributed cause of deeth (Item 23e) (Type, Print)

M. ABHYANKAR

31. Dete filed (Month, Dey, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. B.K.S State of Maryland / Department of Health and Mental Hygiene ALBERT D. MEEK Certificate of Death 27, 28A-F PER MEO G773 7-22-99 WR. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 0045 AM Albert Donald Meek 2, 1999 4c. County of Death JULY /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE BALTIMORE 9610 PULASKI HIGHWAY Hours Min. 8. Dele of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 10 M 2 F 216-34-8288 Director May 7, 1937 Maryland Usual Residence of Decadent the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits Maryland Baltimore 1 Yas 2 No Director Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 9610 Pulaski Highway 21220 death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. 72 hours after 12 Never Merried 2 Merried 21215-0020 1 Yes 2X No Specify: P 3 ☐ Widowed 4 ☐ Divorced White Completed Decedent's Usual Occupation
 (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Delivery Man Furniture Store marked other Baitlmore, Maryland 17. Father's Name (First, Middle Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any Injury or other traumatic event aloca. 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Earl Oscar Meek Agnes Donovan 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise Barbara Myers(sister) 14 Taxi Way, Baltimore, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State Baltimore Cemetery 7/6/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski funeral Home, P.A. of Fineral Service Licens 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and a cardiac or respiratory arrest, or heart failure. List only one cause on each line. 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel FATTY LIVER AND CIRRHOSIS LIVER disease or condition resulting in death) Examine Due to (or es a consequence of): Examiner physician and the burial-transit be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the death certificate Due to (or es a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o 1 Yea 2 No 3 Probably 4 Unknown 0 Records. þ should b 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Wes an autopsy en tech The law page 2 s 4es 1 Z Yes 2 No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home STResidence 8 Other (Specify) MYes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28b. Time of tnjury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Netural 5 Pending 1 Yes 2 No investigation 2 Accident

Division of Vital Certification: To Attending

ne Hospital or Attending n 24 hours after death. ne Funeral Director: Afte pletely filled in by the fun To the Hosp within 24 hor To the Fune completely fi

> Keed 30. Name and address of person who completed cause of audit (Item 23a) (Type, Print) MIK 111 Penn Street, Baltimore, Maryland 21201 HEUDORE 31. Dete filed (Month, Day, Year)

State Registrar

edical

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature end title of certifier

8 Could not be

22. Registrar's Signeture oouts JUL 0 8 1999

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

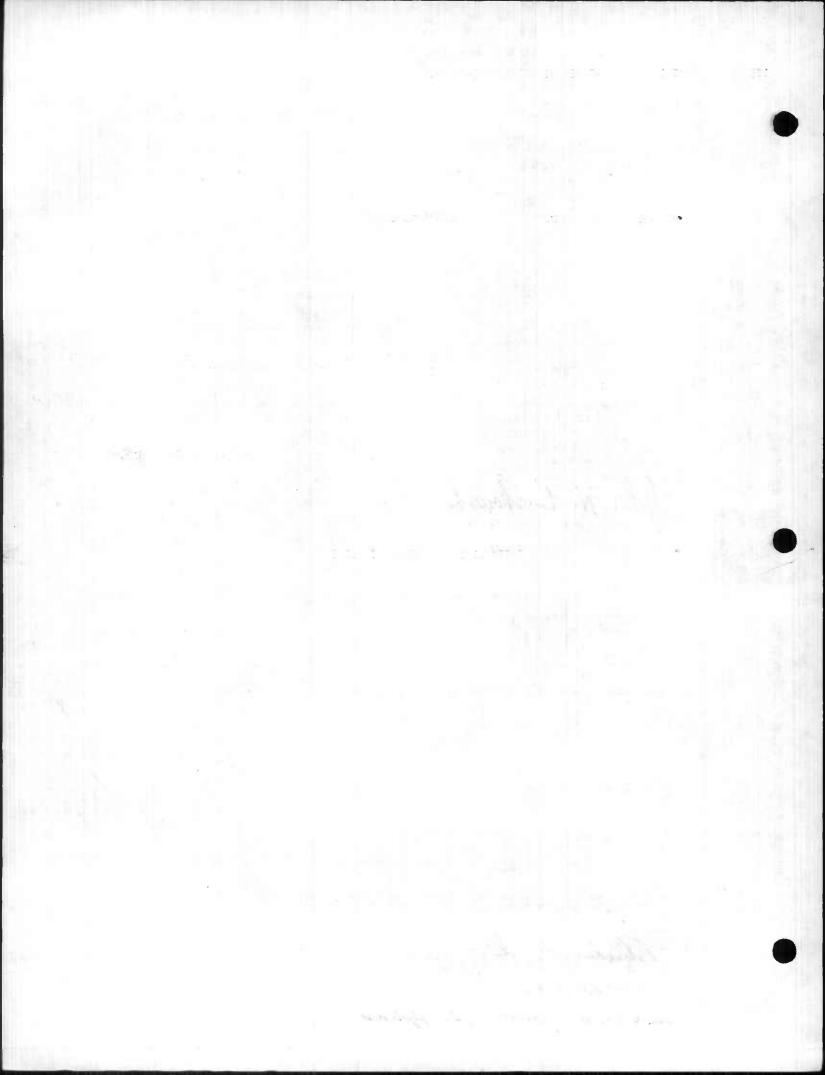
O.C.M.E

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dey, Year)

JULY 2, 1999

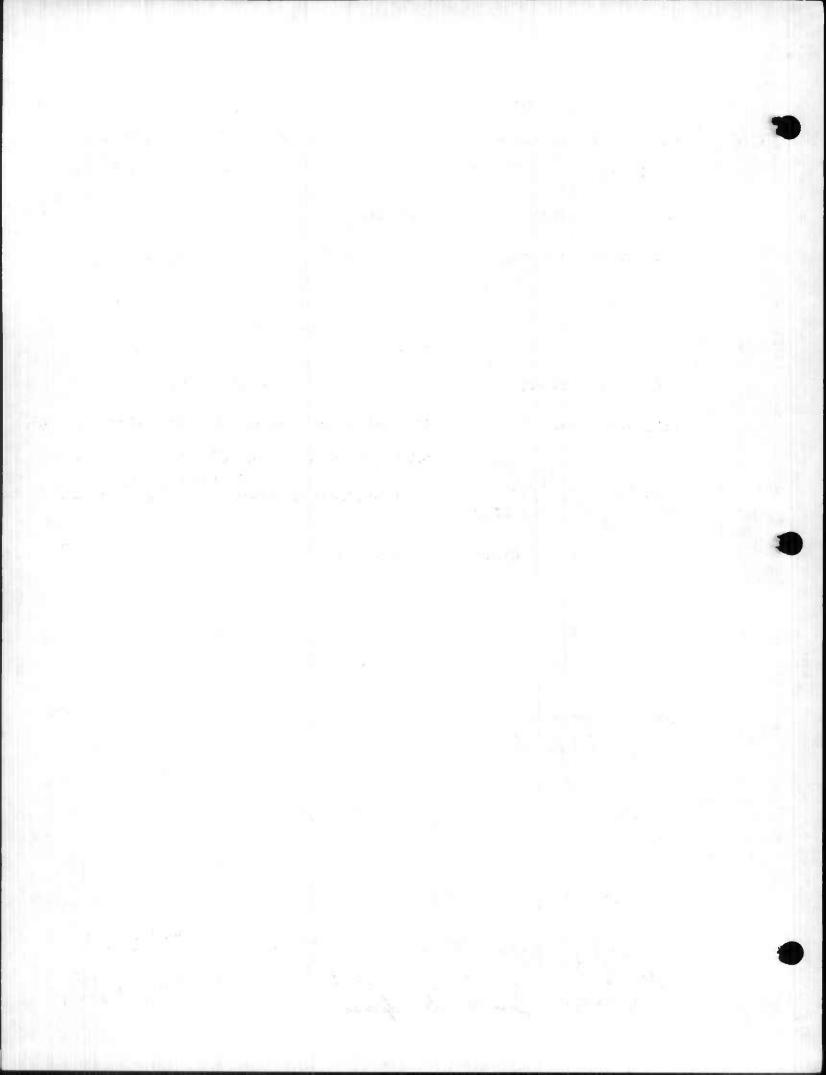


#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 21466

						Cei	rtificate of	Death		Reg. No.		
	Dhuain		1. Decedent's Neme (First, Midd						2. Dete of Dec	eth	Voer	3. Time of Deeth
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9	Exami		4e. Fecility Neme (If not Institution		er)			4b. City, Town, or		,		
1	10		Spa Creek Nur					Annapo			Arun	
	Funeral Director		5. Social Security Number 214–30–3341  Usual Residence of Decedent	6. Sex 7. 1 □ M 2 🖾 F	Age (In yrs. le 78	yrs.	If Under 1 Year Months Deys	If Under 24 Hrs Hours Min		<sup>7</sup> 1921	9. Birthpl Virg	lece (State or Foreign in) Inia
	show	-	10a. Stete 10b. County	gomery	-	Town or Lo					10	0d. Inside City Limits 1 ☐ Yes 2€2€No
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	ath with the 23a or 3	Funeral Director	10e. Street end Number 412 Christoph				10f. Zip Code 208			U.S.A		
Maryland 21215-0020	filed within 72 hours efter death with the Maryland Hygiene. ther than "natural", or itema 23a or 28a-f show ent, the Medical Examination matter colling at	by	11. Marital Status  1 □ Never Married 2 □ Mai  3 □ Widowed 4 ☒ Divorcei	If Yes Give	es? ☑No		Was Decedent of I f Yes, specify Cub I ☐ Yes 2 ☑ No	Hispenic Origin? (Spen, Mexicen, Puer Specify:	Specify Yes or No- to Ricen, etc.)	14. Rac Ble	ce - America ck, White, e	etc.
5-0	72 h natu	etec	15. Deceder	nt's Educetion est grade completed)		(Give	lent's Usuel Occu	during most of wa	rkina	16b. Kind of B	usiness/Ind	lustry
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and	S la b y	Be	Floyd E. Wa						oris Fox		10)	
7	d 2 should be fi th and Mental H 7 Is marked out traumatic aver	2	19e. Informant's Neme/Reletion			10h Maiiir	n Address /Stree	t and Number or R	ural Bouda Numba	is City of Town	State 7in	Code
	nd 2 she lith and 27 is mu		Allan Kable (									g, MD 20879
re,	jes 1 and 2 of Health a of Item 27 is or other trace		20e. Method of Disposition	,	20b. Ple	oce of Dispo	sition (Neme of netory or other ple	ici nvc.	Dete	20c. Location -		
MO	Peges nent of I nt: If ite		1 □XBuriai 2 □ Cremetion 4 □ Donetion 5 □ Other (\$				Park Ce		7/10/99	Woodla	wn, M	aryland
Baltimore,	permit. Peges Department of Important: If it any injury or once.		21. Signeture of Funeral Service	2010	))		Name and Address	ess of Fecility W	itzke Fu enue, Ca			
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		<u>-</u>	resulting in death)			es e consec					BE	
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Ć,	eath certificate be executed ettending physician and for use as the buriet-transit	Exa	Sequentielly list conditions, if eny, leeding to Immediate ceuse. Enter Underlying Cause (Disease or Injury	1	Due to (or e	es e conseq	uence of):				l.	
68760,	ysicia	cai	thet minered events	c	Due to (or e	es e conseq	uence of):					
68	ng ph as th	Medical	resulting in deeth) Lest	L	200 10 (0)	0 0 0011004	3.7.					
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	0 0 8	Physician/	Part II. Other significant conditi	ons contributing to death	h but not result	ting In the ur	nderlying ceuse gi	ven in Part I.	23b. Did t	obecco use co	ntributa to	the cause of death?
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Rec	hes ye 2	m m	1 4							~	of c	deeth?
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of	Phys r this aral di	7: To	1 Yes 25 No 27. Menner of Death	1 ☐ inpa	njury 2	R/Outpetien 28b. Time of	t 3 DOA 28c. Inju		dome 5 Resid			"
on	Attending In death.	tion	1 Naturel 5 Pendi		Dey Year)	Injury		rk? ]Yes 2∐No				
Division	19 th 19 cm	Certification:	3 Suicide 6 Couid 4 Homicide determ	nined 289. Place of	Injury - At hometc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (S City or Ton		per or Rurei	l Route Number,
	the Hospital of hin 24 hours ethe Funeral C	edical (	29a. Certifier (Check only one)	ng Phyeician: To the bes Examinar: On the basis and manner	s of examination	iedge, deeth on and/or inv	occurred et the ti restigation, in my	me, dete end pleco opinion, death occi	e, end due to the ourred et the time, o	ceuse(s) end me date and piace,	enner es sta and due to	ated. the ceuse(s)
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1			my 1	1 Frum	m	D	DI	1765		// \	5/9	7
			30. Neme and address of person	who completed ceuse o	of deeth (Item 2	23e) (Type,	Print) /	1 1	. 4		12	. /
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Registrar DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEMS #5 & #8 PER FH G773 7/8/99 AH 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** Maderski 2:18 PM 4 Walter /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Boltimore Mary land N/A Hospital University a 5 Social Security Number 218-20-6403 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1926 7. Age (In yrs. last birthday) **Funeral** Sex 1 M 2 □ F Days Hours Yrs Director July 12, 1999 Maryland Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinat must be notified at 1 Nes 2 No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 213 S. Washington 21231 12. Was Decedent Ever in U,S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: ₩₩II 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status permit. Peges 1 and 2 should be filed within 72 hours after of Depertment of Health and Mantel Hygiana. Important: if Nem 27 is marked other than "natural", or iten any Injury or other traumatic evant, the Medical Exercises 2008. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mail Carrier U.S. Post Office 12th 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Walter Joseph Madejski Irene Ziomek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita M. Madeiski/Wife 213 S. Washington Street Baltimore, Maryland 21231 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burlai 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 7/8/99 Baltimore, Maryland St Stanislaus Cemetery 22. Name end Address of Facility David J. Weber Funeral Homes, P.A. M00535 401 S. Chester St. Baltimore, Maryland 21231 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fluid only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical nmediate Ceuse (Finat isease or condition esulting in death) a Right Ventricular Failure after Covering Reverolarization Examiner Examiner Myocardial attending physician and for use as the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? the 1 Yes 2 No 3 Probably 4 Unknown yd bengis Artery Disease, Hypertension, Division of Vital Records, Ď 24b. Were eutopsy findings evallable prior to completion of cause ot deeth? 24a. Was an autopsy performed? Non-Insulin Deservelent Dicholes Mellitus certificate has 200110 1 ☐ Yes 2 ☐ No Attanding Physician: 25. Wes case reterred to medical exeminer? Be 28. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 2 1 tnpatlent 2 ER/Outpetient 3 DOA After this of 27. Menner ot Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Certification: 5 Pending Investigation death. 1 Yes 2 No within 24 hours efter deam.
To the Funeral Director: A 2 Accident 6 Could not be 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide ò Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

31. Date tited (Month, Day, Year) JUL 0 8 1999

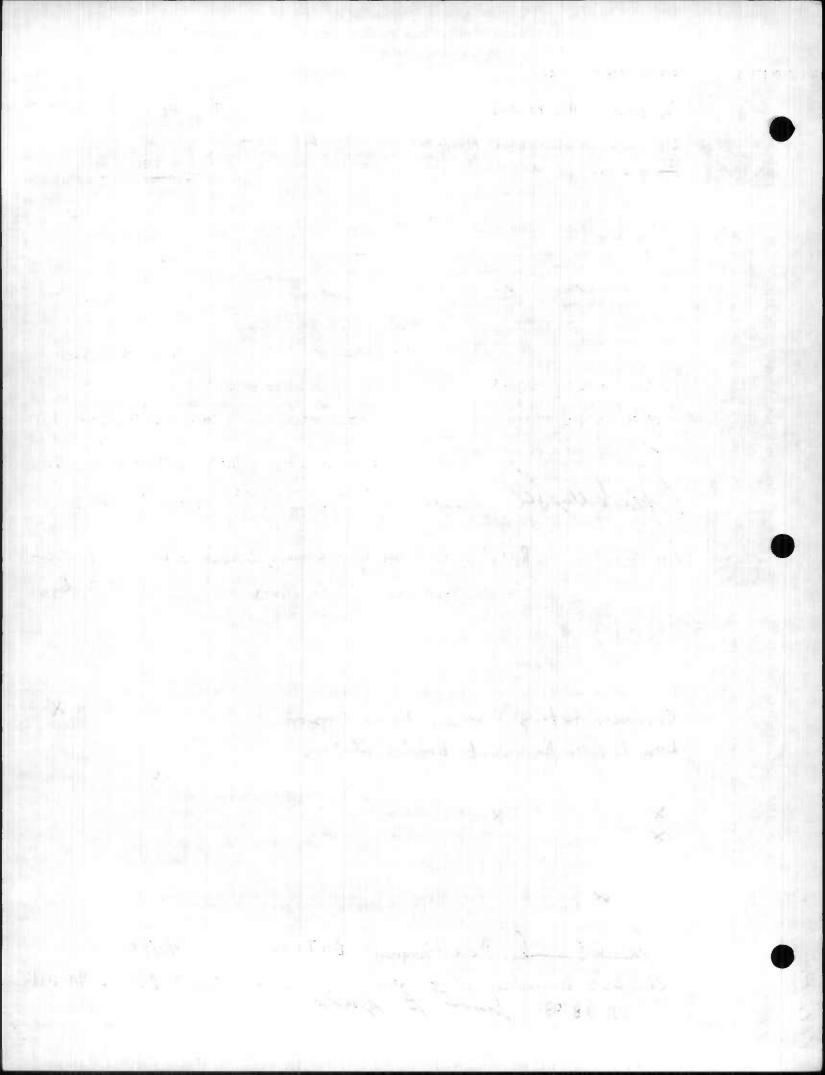
THE 32 Registrer's Signature

Resident Surgeon

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

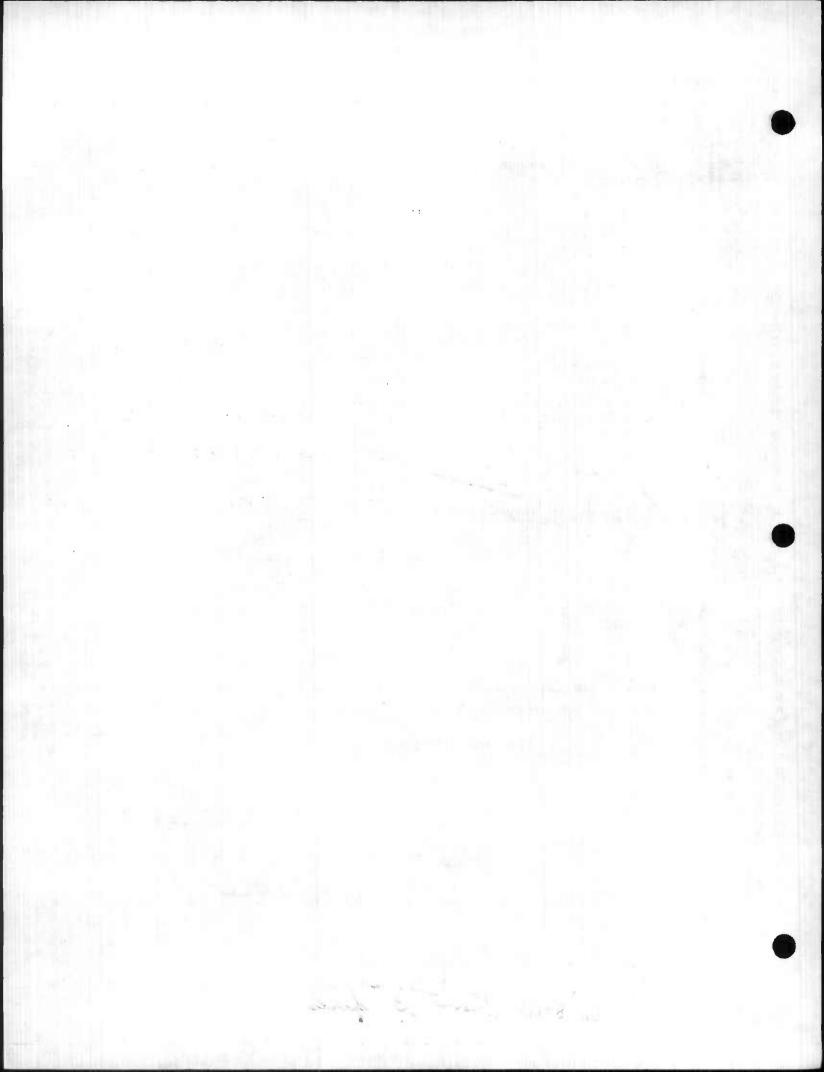
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22 S. Greene Street Boltimore, MD 2/128 Drummond, Charles S.



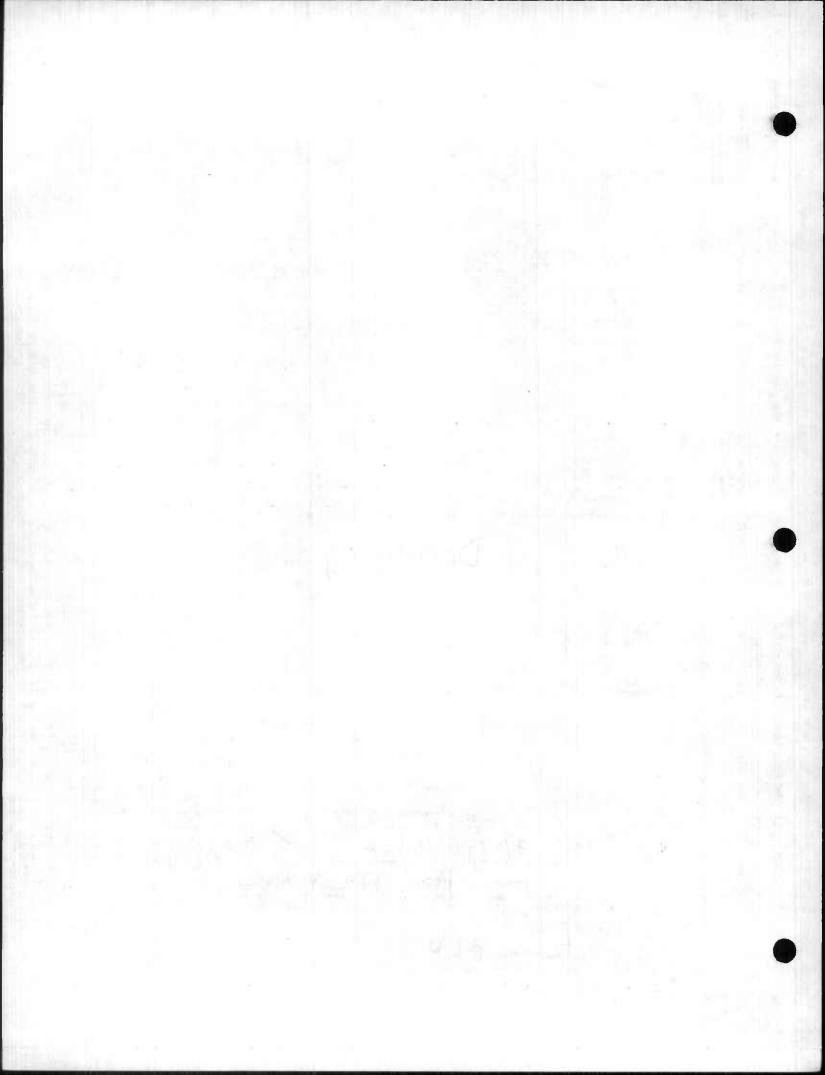
## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			Ce	rtificate of	Death		Reg. No.	9 21468			
Dhuaisian	1. Decedent's Name (First, Middle, La.	st)				2. Date Mon	of Death th Day	3. Time of Death			
Physician /Medical	ANN			MILLER		JUI		1999 5:30AM			
Examiner	4a Facility Name (If not institution, give	e street end number)			of Death						
84	PIKESVILLE NURS				PIKES			LTIMORE			
Funeral Director	213 24 3012	D	s. <i>last birthday)</i> 93 Yrs.	If Under 1 Year Months Days		Min. 8. Date	of Birth th, Day, Year, 1906	9. Birthplace (State or Foreign Country) RUSSIA			
P .	Usual Residence of Decedent  10a. State 10b. County	10c (	City, Town or Lo	ocation				10d. Inside City Limits			
the Marylar 28s-f show cuffied at	MD BALTIMO		BALTIM					1 ☐ Yes 2 No			
uth with the Mar 23a or 28a-f a unit be mouthed	7 SUDBROOK LANE			10f. Zip Code	21208		10g. Citizen of What Country? U.S.A.				
urs after dear, or flems	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		Was Decedent of if If Yes, specify Cub 1☐ Yes 2☐ No		n? (Specify Yes Puerto Rican, et	or No- c.) 14. Rac Blac Specify	e - American Indian, ck, White, etc.			
72 hours Tratural,	15. Decedent's Ed (Specify only highest gra		16a. Decer	dent's Usual Occup	pation during most o	of working	16b. Kind of B	usiness/Industry			
od within 72 ho og within 72 ho ygjene. At the Medical At the Medical Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	life. DO NOT use retired) PROPRIETOR			LIOUOR	STORE			
filed with Hygiene. Hygiene. the mt. the the mt. the m	17. Father's Name (First, Middle, Last)		1110111	IDION	18. Mother's	s Name (First, A	Aiddle, Maiden Suman				
aryland 212 should be filed within nd Mental Hygiene. marked other than umatic avent, the M	(UNKNOWN)		KATZ				(UNKNOWI				
2 2 2 2	19a. Informant's Name/Relationship (I						ral Route Number, City or Town, Stete, Zip Code)  —BALTIMORE, MD 21201				
0 0 0 2 2	20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □	20b.	Place of Dispo	osition (Name of metory or other pla	ice)	Dete	20c. Location	City or Town, State			
The Particular forces	4 Donation 5 Other (Specify	<u> </u>		RIENDSHIE		ERY ///	/99 BALT	IMORE, MD			
DEBILLING Permit. Pag Department: Important: It any Injury o	21. Signature of Juneral Service Licensus  22. Name and Address of Facility  SOL LEVINSON & BROS., INC.										
Physician /Medical Examiner	23a. Part 1. Enter the disease, or composition of the control of t	a	ath. Do not ent	er the mode of dyi	ng, such as ca	ardiac or respira	PIKESVILLI tory arrest,	Approximate Interval Between Onset and Death			
ē	1307	1									
death certificate be executed eath certificate be executed of for use as the buriet-transit citan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	C	(or as a conseq		) ((	love					
attendin Ifor usa											
that the death certified by the attending detached for use a / Physician/M	Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of d				
The law requires that the de sate has been signed by the page 2 should be detached Completed by Physic		Severe	dem			24a	24a. Was an sutopsy performed?  24b. Were autopsy f available prior to completion of completion of death?				
The la			-Alzh	leines			1□ Yes 2No	1 ☐ Yes 2 ☐ No			
relcian: The s certificata director, pag	25. Was case referred to medical examiner?				26. Place o	of Death (Check	only one)				
Z 0 0	1 ☐ Yes 2 № No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatier	I 3 DOA	her: 48 Nurs	sing Home 5	Residence 8 Oth	er (Specify)			
Attending Ph ar death. ector: After th by the funeral	27. Manner of Death 1 Netural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	ryet rk? ]Yes 2 □ No		cribe how injury occur	red			
tal or Attending P is after death.  al Director: After to be the funer led in by the funer Certification:	3 Suicide 6 Could not be determined	28e. Plece of Injury - At building, etc. (Spec	home, larm, str	reet, factory, office		28f. Loca City	ocation (Street and Number or Rural Route Number, City or Town, State)				
n 24 hospi n 24 hour ne Funer pletely fill edical		ratclan: To the best of my kn finer: On the basis of examin end menner steted.									
To the within To the com	29b. Signature and little of certifier	-0		29c. License number 0 37 573				d (Month, Day, Year)			
8	30. Name and address of person apply of Zibell, A	completed cause of death (flee	em 23a) (Type,	Print)	te Au		altimore	MD ZIZO8			
State Registrar	31. Date filed (Month, Dey, Yest)  JUL 8	32. Registrar's Sign		Spar	w						



### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	Certifi	cate of Death	Reg. No.	21900					
Physician /Medical	1. Decedent's Nama (First, Middla, Last)  Austin Taylor Mulli	2. Data of Death Month Day Yea JULY 5, 1999	3. Tima of Death 1749 PM						
Examiner	4a Facility Nama (If not institution, give street and number)  JOHNS HOPKINS BAYVIEW MEDICAL CENTER B	4b. City, Town, or L	,	eth					
Funeral Director	5. Social Security Number  6. Sex 1    N 2   F 3   Yrs.   7. Age (In yrs. last birthday) Model  Mod	Under 1 Yaar   If Under 24 Hrs. nths Days Hours Min.	8. Data of Birth (Month, Day, Year) 9. 8	irthplace (Steta or Foreigr Country) Iaryland					
yland	Usual Rasidanca of Decedent  10a. Stata 10b. County 10c. City, Town or Location	n		10d. Inside City Limits					
vith the Mar or 28a-f si be notified Director	Maryland Baltimore Dundalk  10e. Street and Number 10g. Critizen of Wr								
with the sor 2 Liberal	10e. Street and Number 8166 North Boundary Road	Ol. Zip Code 21222	10g. Citizen of What C						
n 72 hours after death with the Maryland "natural", or learn 23a or 28a-f show edical Examiner must be notified at leted by Funeral Director	11. Marital Status  12. Wes Decedent Ever in U,S. Armed Forces?  1 ☑ Nevar Merried 2 ☐ Married 1 ☐ Yas 2 ☑ No	Decedent of Hispanic Origin? (Sp., specify Cuban, Mexicen, Puerto es 2 No Specify:	pecify Yas or No- Prican, etc.) 14. Race - An Black, Wi	nerican Indian,					
within then then	15. Decedant's Education (Specify only highest grade completed)  Elamentary/Secondery (0-12)  College (1-4or 5+)	Usual Occupation of work dona during most of work OT use retired) eendant	16b Kind of Busines	s/Industry					
be filed d other event, the	17. Fathar's Nama (First, Middle, Last)		a (First, Middle, Maiden Sumame)	1					
should be nd Mental marked o imatic ev	Harve Mullins, Jr.	Sherr	cy Jean Poling						
d 2 sho th and 7 la ma traum		A STATE OF THE STA	ral Routa Number, City or Town, State Road Dundalk, Mar						
F 1 an Heal ferrit	20e. Mathod of Disposition 20b. Plece of Disposition	(Nama of	Data 20c. Location - City of	-					
emit. Pages 1 ar Pepartment of Hea mportant: If Hem i my Injury or other MGB.	1⊠ Burial 2 □ Cramation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify) Sacred Ht.	of Jesus Cem.	7/10/99 Dundalk	_Maryland_					
permit. Page: Department of Important: If I any Injury or once.	21. Signature of Funaral Sarvice Licensee  22. Nama and Addrass of Facility  Duda-Ruck Funeral Home of Dundalk,  7922 Wise Ave. Dundalk, Maryland								
physician and strength and stre	Immediate Cause (Final disaasa or condition rasulting in death)  Sequentially list conditions, if any, leeding to immediate cause. Entar Underlying Causa (Disease or Injury that initiated evants rasulting in death) Last  Due to (or as a consequence cause. Entar Underlying Causa (Disease or Injury that initiated evants rasulting in death) Last  Due to (or es a consequence cause. Entar Underlying Causa (Disease or Injury that initiated evants rasulting in death) Last	e of):							
THE LOS AND	d			1					
d by the detached detached	Pert II. Other algnificant conditions contributing to death but not resulting in the under	ying ceusa given in Part I.	23b. Did tobacco use contribu	rta to the cause of death Probably 4 Unknow					
The law requires to page 2 should be completed by		+-	24a. Was an autopsy performed?  ZNSPECTION  1 DYSS 2 MNo	o. Were autopsy tindings available prior to completion of ceuse of death?					
entitio actor.	25. Was case retarred to medical axaminar?		th (Check only one)						
To the Hospital or Attending Physician: Twithin 24 hours after death.  To the Funeral Director: Aher this cartificat completely filled in by the funeral director, p. Medical Certification: To Be C.	27. Manner of Deeth 1 Natural 2 Natural 2 Natural 3 Suicide 4 Homicida  29a. Certifier (Check only one)  1 Certifier (Check only one)  1 Inpatiant 2 Natural 2 Natural 3 Suicide 4 Homicida  28a. Data of Injury (Month, Day Year) 28a. Plece of Injury - At home, farm, street, if building, atc. (Speety)  29a. Certifier (Check only one)  29b. Signatura and titla of certifier	28c. Injury at Work? 1 Yes 2 No actory, office 166 N. Bound	red at the time, date and place, and d  29d. Date signed (Mo	pool and drown Hural Route Number, Himo me, Md as stated. us to the cause(s)					
State	30. Name, and eddress of person who complated cause of death (Item 23a) (Type, Print  Pesture 111 Penn 3  31. Data filled (Monifi Day, Year)  32. Registrer's Signature		re, Maryland 2120						



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month 3. Tima of Death Michael E. Nemuras July 7, 1999 6:15 AM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Perry Point Co VA Maryland Health Care System 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 50 yrs. Birthplace (State or Foreign Country) 5. Social Security Number Months 220-56-8949 22,1949 Maryland Feb. Usuai Rasidance of Decedent 10c. City, Town or Location Pasadena 10e. Stete 10d. Inside City Limits 10b. County Anne Arundel Maryland 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21122 7972 Catherine Avenue 12. Wes Decedent Ever in U,S. Agned Forces? 1 ⚠ Yes 2 ☐ No If Yes, Give Year or Detection Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American indian, Bleck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedant's Usuai Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Salesman 17. Father's Neme (First, Middle, Last) 18. Mother'a Name (First, Middle, Maldan Surname) Margaret Meek Nemuras Edward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 7972 Catherine Ave., Pasadena, Maryland 21122 19a. informant's Name/Relationship (Type, Print) Edward Nemuras (father) 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State County 20a. Method of Disposition 1 X Buriai 2 ☐ Cremation 3 ☐ Removel from State Vet. Cem. (Garrison For)7/12/1999 4 ☐ Donation 5 ☐ Other (Specify) Maryland 22. Name end Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, Md. 21122 Part1. Enter the disease, or complications that sed shock, or heart feilure. List only one cause on such lire sed the death. Do not enter the mode of dying, such es cardiac or raspiratory arrest, 23a. Part1 Approximata Interval Between Onset and Deeth Immediata Cause (Final disease or condition resulting in daath) 29 Minutes Myocardial Infarction Due to (or as a consequence of) Sequantially ilst conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequence of) Due to (or as a consequence of) Pert li. Other stgniftcant conditione contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Dfd tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were eutopsy findings available prior to completion of cause of daath? 24a. Was an autopsy performed? 1 Yes 2 No 26. Place of Death (Check only one)

**Physician** /Medical **Examiner** The law requires that the death certificate be executed

permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If Item 27 is merked othe any injury or other treumstic event bitte.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23s or 28s-f ahow The Medical Examiner must be notified at

Direct

Funeral

þ

Completed

the Maryland

death

filed within 72 hours after Hygiene.

ettending physician end for use es the buriel-transit 98 9SN signed by the e been : certificate has

Box 68760.

P.0.

Division of Vital Records,

or Attending Physician:

To the F within 2

Examin 24 hours after death. Funeral Director: After this funeral Certification:

Physician/Medical þ Completed Be 2

25. Wes case referred to medicel axaminar?
1 ☐ Yes 2 ☐ No

27. Manner of Death 1 X Natural

> 2 Accident 3 Suicida 4 Homicide

29a. Cartifian

5 Pending

investigation 6 Could not be

Hospital: 1 1 tnpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Date of injury (Month, Day Year)

28e. Place of injury - At home, farm, streat, factory, office building, etc. (Specify)

28b. Time of

Other: 4 Nursing Home 5 Rasidanca 6 Other (Specify) 28c. injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s)

29b. Signature and title of centifier

and manner stated.

29c. License number D42800

29d. Date signed (Month, Day, Year)

July 7, 1999

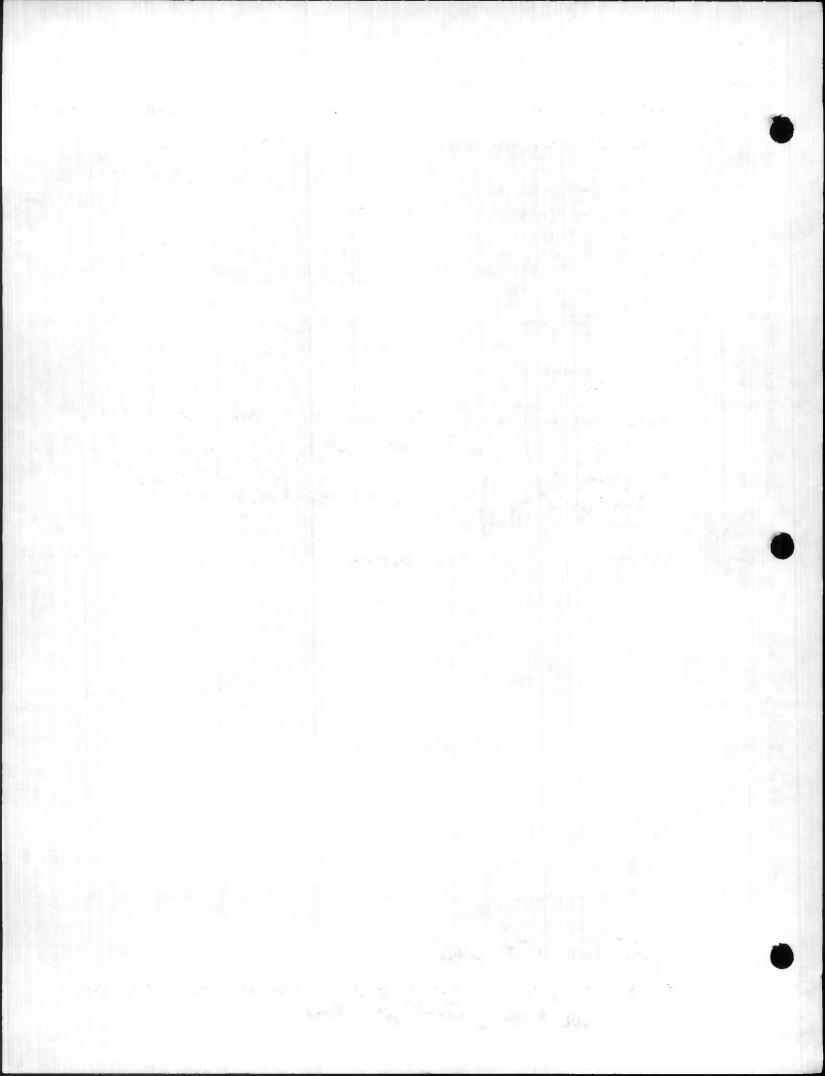
30. Name end addresa of person who completed cause of death (Item 23a) (Type, Print)

THOMAS BIANDO, M.D., VA Maryland Health Care System, Perry Point, MD 21902
31. Date filed (Month, Day, Year) 32. Register Signature 32. Registral's Signature

State Registrar

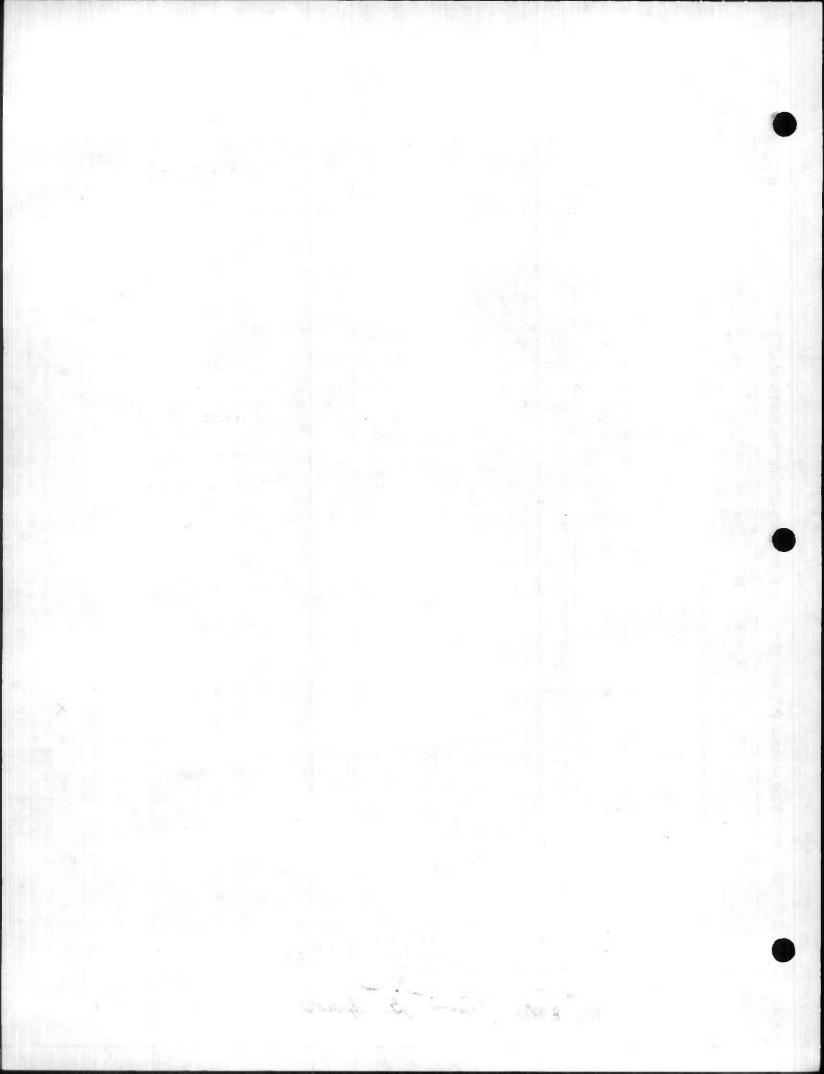
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Outland 1999 16:46 uly Dusan 02 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore System | If Under 1 Year Baltimore
If Under 24 Hrs. 8. Date
Hours Min. Dec MARYland University of Medical 8. Date of Birth (Month, Day Y Dec • 20 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country)
 Maryland **Funeral** Months Days 1 M 2 KF 213-76-5778 47 Director Usual Residence of Decedent with the Maryland r 28a-f show 10s. Stata 10b. Counts 10c. City, Town or Location 10d. Inside City Limits Md. Talbot. St. Michaels 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 than "natural", or items 23s or the Medical Examiner must be 21663 Box 62 USA Funeral filed within 72 hours after death Hygiene. other then "natural", or flerms 23 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, atc. 11 Marital Status 1 ☐ Yes 2 ☒ No 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 20 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th Ccok Restaurant marked other traumatic avent, permit. Pages 1 and 2 should be flie Department of Health and Mental Hy Important: If flem 27 te marked othe Any Injury or other treumatic avent pages. 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be Thelma Pinning Thomas R. McCreer Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 317 Savannah Road Baltimore Md. 21221 Donna Cook / sister 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Daurial 2 Cremetion 3 Removal from State Belair Memorial Gardens 7/7/99 4 ☐ Donation 5 ☐ Other (Specify) Bel Air 21. Signature of Funeral Service License 22. Name and Address of Facility Connelly Funeral Home of Essex 00 300 MAce Ave. Baltimore Md. 23a. Part1. Entar the disease, or hour shock, or heart failure. Lightenly mb cations that caused the down. Do not enter the mode of dying, such as cardiac or respiratory arrestly one cause on each lina. Approximata tntarval Between Onset and Death Physician Immediata Cause (Final disease or condition resulting in death) /Medical Pneumonia month Examiner Due to (or as a consequenca of). Examiner physician and the burlai-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760. Physician/Medical Due to (or as e consequence of) 80 980 signed by the a Part if. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably WUnknown λq 24b. Wera autopsy tindings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 s certificate 1 ☐ Yas 2 No Division of Vital or Attending Physicien: director, Be 25. Was case reterred to medical examiner? 26. Placa of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Unpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation Natural death. 1 Yes 2 No 2 Accident 24 hours after deat Funerel Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, sfreef, factory, office building, etc. (Specify) 2 4 Homicide filled in Hospital Cortifying Physician: To the best of my knowledge, daath occurred at the tima, data and place, and due to the cause(s) and manner as stated. edical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) To the To the To the 29b. Signature and title of certifie 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and addr eled causa of daath (ttem 23a) (Type, Print) to compl 22 South Greene Street Baltimore Md. 32. Registral's Signature 31. Date filed (Month, Day, Year) State eper JUL 8 1999 Registrar

AHE



Physician /Medical Examiner	1. Decedent's Name (First, Middle, La	ist)				2. Date of De		3. Time of Death
	CLIFFORD JOH	N PHILIPS				Month July	04. 199	9 9:00 A.M.
	4e Facility Neme (If not institution, gh	ve street end number)			4b. City, Town	, or Location of Deat		of Death
	Union Memorial I	Hospital			Baltin If Under 24	nore	N/A	
eral	5. Social Security Number 6. 9 134-24-8202	Sex 7. Age (In yrs. le	ast birthday) Yrs.	If Under 1 Year Months Days		Min. April	25, 923	Birthplace (State or Foreign Country)
or	Usuel Residence of Decedent	VV 00	113.			Aprii .	25, 1923	-New York
	10a. Stete 10b. County	10c. City	, Town or Loca	ition				10d. Inside City Limits
tor	Maryland N/A	Ba1	timore					1  Yes 2 No
Directo	10e. Street end Number		O XIII O I C	10f. Zip Code			10g. Citizen of \	What Country?
	725 Stoney Spring	s Drive		21210			USA	
Funeral	11. Maritel Stetus	12. Wes Decedent Ever in U.S Armed Forces?	H Y	as Decedent of I res, specify Cub	Hispanic Origin van, Mexican, F	? (Specify Yes or No Puerto Rican, etc.)		e - American Indian, ck, White, etc.
by F	1 ☐ Never Married	1) XYes 2 No 51 - If Yes, Give Yeer or Detes:	53	Yes 200 No	Specify:		Specify	White
	15. Decedent's E		16a Decede	nt's Usuel Occup	nation		16b Kind of Br	usiness/Industry
Completed	(Specify only highest gri	ade completed)	(Give ki	nd of work done NOT use retire	during most of	working	TOO. TURG OF DE	and the same of th
mo	Elementery/Secondery (0-12)	College (1-4or 5+) 5+	Acco	untant			Teleph	one
Bec	17. Fether's Neme (First, Middle, Last	)			18. Mother's	Name (First, Middle		
To	Edward Philip	S			Floren	ce Cather	ine Van	Pelt
74.	19e. Informent's Neme/Reletionship (					or Rural Route Numb		
	Eileen R. Philips				orings			Maryland 21212
	20e. Method of Disposition XX Buriel 2 ☐ Cremation 3 ☐	Removel from State		tory or other ple		Date		City or Town, Stete
	4 Donetion 5 □ Other (Special	AA		orest VA		7/9/99		Mills, Maryland
	21. Sofature of Funeral Service Liber	tal IV	h 22.1	Name and Addre	ess of Fecility	Mitchell-V	Viedefeld	Funeral Home Inc.
	Nums 19	Selver tenas				altimore,		
	23a. Pert1. Enter the disease, or con shock, or heart feilure. List only	plications the caused the deeth. one cause of such line.	. Do not enter	the mode of dyi	ing, such es ca	rdiac or respiretory a	irrest,	Approximete Intervel Between Onset and Death
n al	Immediete Cause (Finel	ATHEROCCI EROTTO	CARDION	ACCHI AD D	YCE ACE			
er	disease or condition resulting in deeth)	ATHEROSCLEROTIC	es a conseque		ISEASE			
ne		00 (0)	es a consequi	arce dry.				
Examiner	Sequentially list conditions,	b. Due to (or	es e conseque	ence of):				
	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury							
dicai	thet initiated events resulting in death) Lest	Due to (or	es e conseque	nce of):				
Me		d						
Ciar						1		
by Physician/Med	Pert II. Other significant conditions of	contributing to death but not resul	ting in the und	enying cause gi	ven in Pert I.			ntribute to the cause of death?  3 Probably 4 Unknown
Y							Yes 2,20 No	OF FIGURE 4 CONTROL
2						24a. Wes	s an autopsy ormed?	24b. Were autopsy findings aveilable prior to
Completed						pen	omieur	completion of cause of death?
E						1,20	Yes 2□No	1 Yes 2□ No
BeC	25. Wes case referred to medical				26. Place of	Deeth (Check only	one)	
To	examiner? 1 △ Yes 2 ☐ No	Hospitel: 1 Inpatient ZDE	R/Outpatient	3□ DOA Ot	her: 4 🗆 Nursi	ng Home 5 ☐ Res	idence 6 🗆 Oth	er (Specify)
on:	27. Menner of Deeth 1 ☑ Netural 5 ☐ Pending	28a. Dete of Injury (Month, Day Year)	26b. Time of Injury	28c. Inju Wo		The Part of the Pa	how injury occur	red
cati	2 Accident Investigation 3 Suicide 6 Could not be				Yes 2 □ No			
E	4 Homicide determined	28e. Plece of Injury - At hor building, etc. (Specify)	ne, ferm, stree	t, factory, office		City or To	(Street and Numb wn, Stete)	per or Rural Route Number,
- 63	20a Cadillar 1 Cadilla Ph	unitalist. To the heat of my leave	dadaa daath a	anymod of the ti		door and due to the	saves(a) and no	
To the Funeral Director: Completely filled in by the f Medical Certificati		nystclan: To the best of my know niner: On the basis of examinetic end menner steted.						
dicai C		GITO INTO STOREGY.		29c. Licens	se number		29d. Date signe	d (Month, Day, Year)
Medical Certification:	29b. Signeture end title of certifier					_	1	
	29b. Signeture end title of certifier	A Man	15.	h	O.C.M.I	E.	July 05	1999
	Atys !	A VIIIC	(F) MA	b	O.C.M.I	Ξ•	July 05	, 1999
	Atys M 30. Neme end address of person who	A Vuc completed cause of deeth (Items Raden + 2.		int)				, 1999 Land 21201
Wedical Co	Atys !	Radentz, 32. Registrer's Signatu	11	int)	Street			

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make the medical marginal

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** RAYNOR 3:32 AM REDERICK July /Medicai Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore N/A Rehabilitation + Extended Cire Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1MM 2□ F 83 217-09-4189 25, 1916 MD March Usuei Residence of Decadent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Baltimore Bowleys Quarters 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 10 Olivia Ct. USA Funeral 12. Was Decedent Ever in U,S Armed Forces? 11. Maritel Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ⊠ Yes 2 □ No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married by 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 DWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) Coilege (1-4or 5+) Hot Roll Inspector Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Raynor Mary E. Jackson 2 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 10 Olivia Ct. Charles F. Raynor /son Baltimore, MD 21220 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Date July 1999 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Facility
Connelly Funeral Home of Dundalk Sollers Point Rd 21222 23a. Pert i. Enter the disea of or complications that caused the dept. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Finai multiinfaction type Dementia, diseese or condition resulting in death) Due to (or es a consequença of) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Pert il. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown b 24b. Were sutopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? 1 ☐ Yes 2 DINO 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homiclde 1 Dertifying Physician: To the best of my knowledge, death occurred et the time, date end piece, and due to the cause(s) and manner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piace, and due to the cause(s) end manner steted. Medical (Check only one)

The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician: after death To the Hospital within 24 hours a To the Funeral C Hospital

**Funerai** 

Director

28a-f show

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items 23s

Pages 1 end 2 should be filed within 72 hours effer death nent of Health end Mental Hygiene.
nt: If Item 27 is marked other than "natural", or items 23

nt of Health e If Itam 27 is or other tra

permit. Page Depertment of Important: If any Injury or once.

**Physician** /Medical

Examiner

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attending physician for use as the bune

signed by t

certificate

After this

6

death.

Se esn

21215-0020

Baltimore, Maryland

traumatic event, the Medical Examiner must be notified at

with the Maryland

State Registrar DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year) JUL 081999

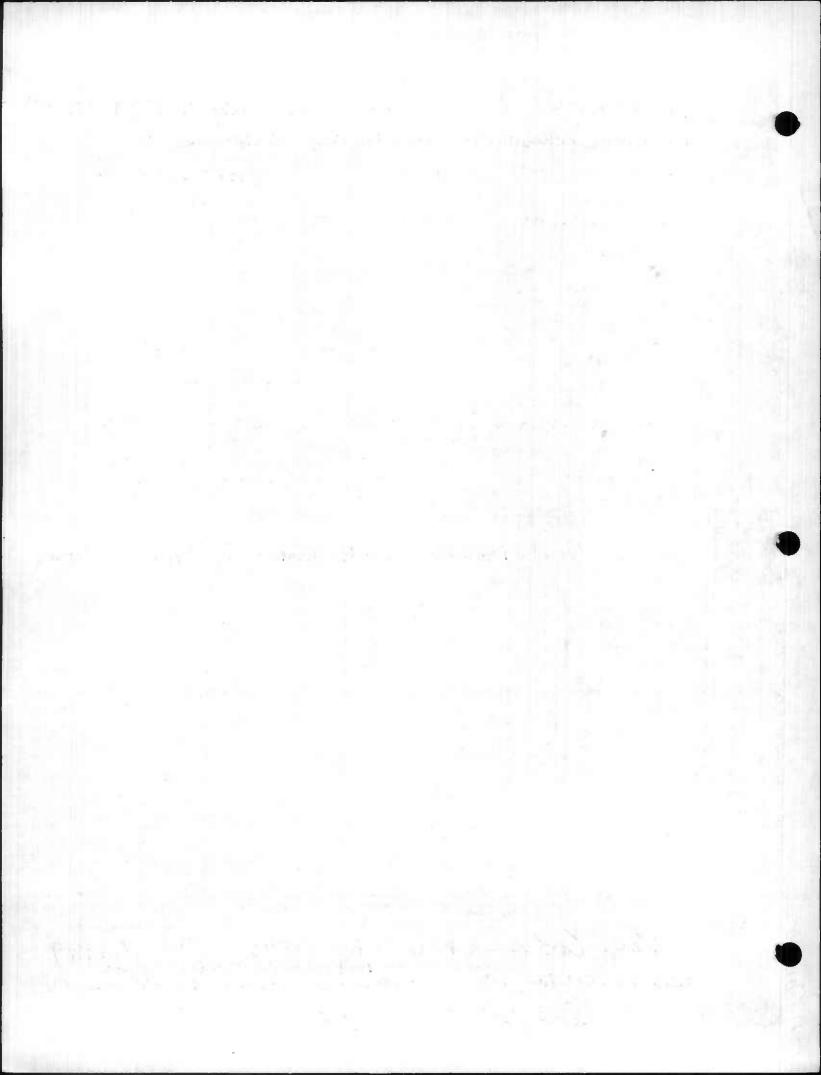
29b. Signature and title of certifier

30. Name and address of person who completed cause of death (item 23a) (Type, Print) Baltimore VA Medical Center PERRY L. COLVIN MD 10 N. Greene Street, Baltimore 32. Registrer's Signature

29c. License number

D0032548

29d. Date signed (Month, Day, Year)



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Sarah E. Ruth 1999 7:20 11. JULY /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street end number) 4c. County of Death Examiner ROSEDALE FRANKLIN SQUARE HOSPITAL CENTER BALTINORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplaca (Stete or Foreign Country) 6 Say 8. Date of Birth (Month, Day, Year) Hours 1□ M 2□XF Months Days October 1,1930 Alabama 213-26-4430 Usual Residence of Decedent 10d. inside City Limits 10e. Stete 10b. County 10c. City, Town or Location ESSEY Maryland Baltimore 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21221 8620 Kelso Drive Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - Amaricen Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2010 No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married White 1 Yes 2 No Specify: by 3 ☐ Widowed 4 N Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home House Wife 10 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Be Essie Grantham Lee B. Hunt, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 54 Rockywood Lane, Baltimore, Maryland 21221 Stephinie Deese (Daughter) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete Georgetown, Georgia 7/8/99 Georgetown Cemetery 4 Donation S □ Other (Specify) 22. Name and Address of Fecility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 rons that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, cause on each lina. Approximata Intervel Between Onset and Death Immediata Causa (Final ATHEROSCLEROTIC CORDLARY VASCULAR DISEASE 10 KEARS disease or condition rasulting in death) Dua to (or as a consaquance of): Examiner Sequentially list conditions, if any, leading to immadiata causa. Enter Underlying Cause (Disaasa or Injury that initiated evants resulting in deeth) Last Dua to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown SEPS IS ģ 24b. Ware autopsy findings available prior to 24a. Was an eutopsy performed? Completed completion of ceuse of death? 1 Yes 25 No 1 ☐ Yes 2 ☐ No Be 25. Was cesa referred to madicel examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28d. Dascribe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edical

lew requires that the death certificate be axecuted physician end s the buriel-transit Division of Vital Records, P.O. Box 68760 88 080 ed by the a signed t ils certificate has b director, page 2 s The al or Attending Physician: T s aftar death. ii Director: After this certificat ed in by tha funeral director, pi To the Hospital or within 24 hours aft To the Funeral Dis complately filled in

**Funeral** 

Director

r 28a-f ehow

ed other than "natural", or items 23s or event, the Medical Examiner must be a

with the Maryland

72 hours efter

filed within 7 Hygiene.

T and 2 should be Health and Mental marked

Health a

permit. Pages 1 Department of H Important: If the any injury or oth Sticks.

**Physician** /Medical

Examiner

Maryland 21215-0020

State Registrar 29a. Cartifiar

(Check only one)

29b. Signature and title of certifier

SUMMERS no

29c. License number

29d. Date signed (Month, Dey, Year)

aiianga former 30. Name and addrass of person who completed ceusa of death (Item 23a) (Type, Print)

BALTOUIDD LAWANDA 9000

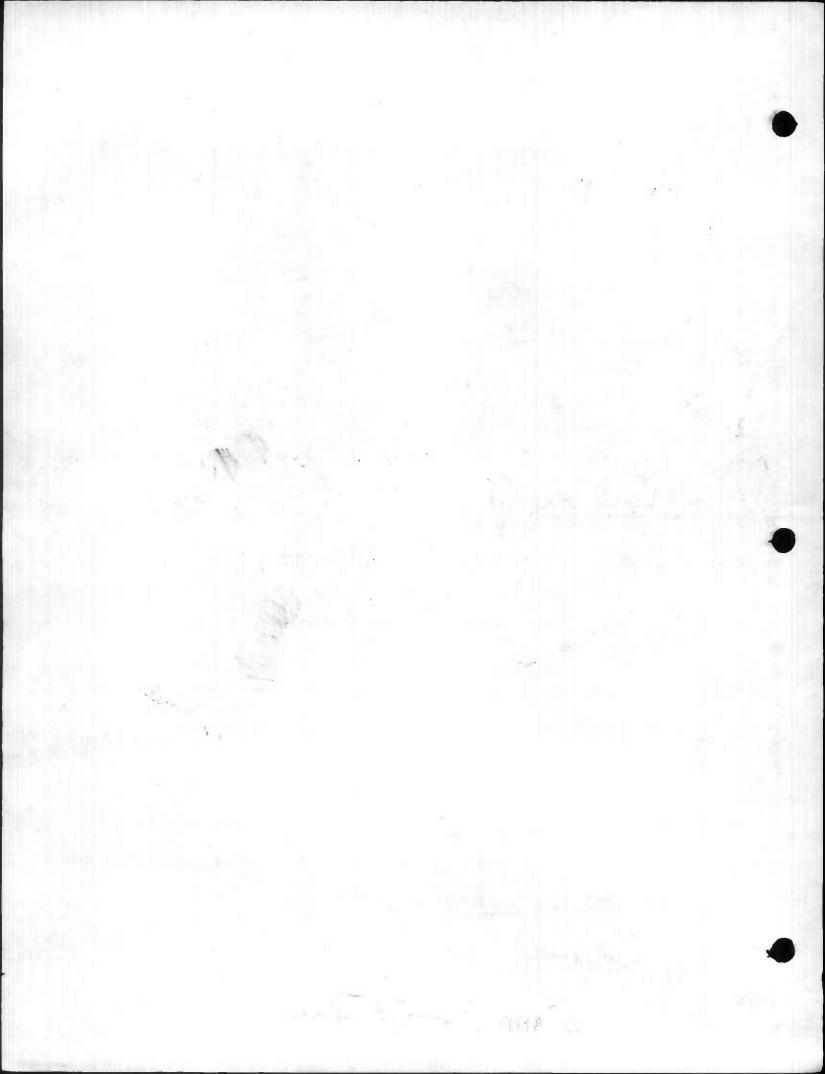
🕯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to tha cause(s) and mannar as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the ceuse(s) and manner stated.

32. Registrar's Signature

Sparks

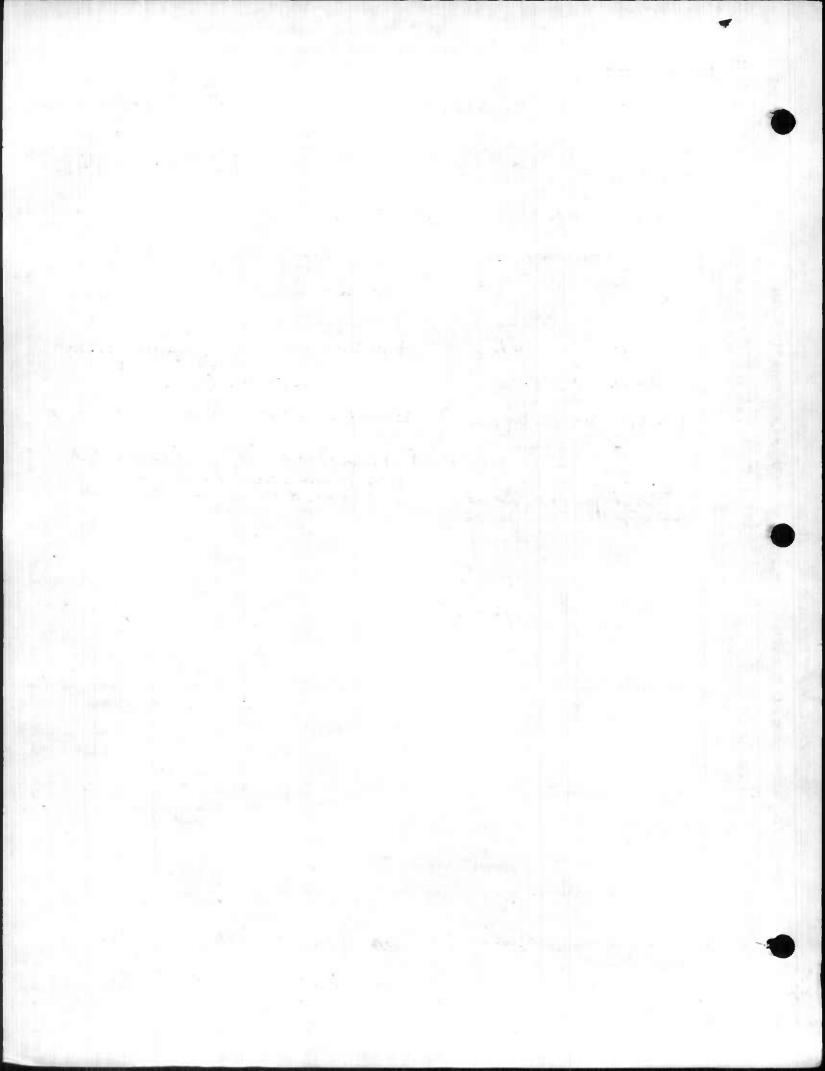
233-09-1163	Rd.  Sex  Val M 2 F  Arunde 1  Rd.  12. Was Deceder Arriged Force 1 Twes 2 F  If Yes, Give Year or Date:	Age (In yrs. last birth 80 Y	or Location Se ve	1 Year Days	Sever	m, or Loca na Pa		3, 199 4c. County An	of Death ine Aru 9. Birthplace Country West V	3. Time of Death 1:45 PM Indel  (State or Foreign inginia	
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(Specify only highest gi Elementery/Secondary (0-12)  7. Father's Name (First, Middle, Las		s: WWII	13. Was Deced If Yes, spec	11		in? (Specil Puerto Ric	y Yes or No- an, etc.)	Specify	e - American I ck, White, etc.	ite	
	College (1-4c		Decedent's Usua 'Give kind of wor life. DO NOT us Min	k done e retired	durina most	of working		16b. Kind of Bu		ry	
Cital les	,	Sterling				's Nama <i>(F</i> dith	irst, Middle,	Maiden Sumam Joh			
19a. Informant's Name/Reletionship  Dorothy E. Ster  10a. Method of Disposition		e) 13		ness		Sever	na Par	r, City or Town, k, Md.	21146		
1 Deurial 2 Cremation 3 [		cemetery	Hill M	her place				Mt. Cla			
21. Signature of Funerel Service Licu	gsee \		Stalli	ngs	Funer	al Ho		, Md. 2	4400		
23a. Pert1. Enter the disease, or con shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	. Cliron	Due to (or as a co	tuctive	of dyir	linm	ardiac or n	Disease	rest,	Ap	proximate erval Batween set and Death	
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of West and the state of									1 🗆 Yı	es 2 No	
axaminer?	Hospital:			Oth	00						
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1 Natural 5 Pending investigation 3 Suicide 6 Could not t	on Diese of I		М	10		lo				oute Number.	
4   Homicioe	building,	etc. (Specify)					City or Tow	m, State)			
	miner: On the basis	of examination and/	death occurred of or investigation,	in my o	ne, date and pinion, death	place, end occurred	at the time, o	date and place,	and dua to the	d. e cause(s)	
9b. Signature and title of certifier	. up	/	290				2		d (Month, Day		
1 ( the				042	820			July	5, 19	99	
O. Nama and address of person who Christopher DeE	completed cause of	odath (Nom 23a) (T )8 Mountai	ype, Print) n Rd. P			Md. 2	1122	July	5, 19	99	
Si sacción de la companya de la comp	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last  ort II. Other significant conditions  ii. Was case referred to medical axaminer?  I was 2 No  Manner of Death  Andural 5 Pending investigatic auses (Disease or injury at initiated events sould not a condition or injury at injury, at injury at injury at injury, at injury at injury, at injury	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury at imiteled events soulting in death) Last  6. Wes case referred to medical axaminer?  1	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury at imiteled events southing in death) Last  Due to (or as a condition of the condition of t	Due to (or as a consequence of):    Due to (or as a consequence of):	isease or condition sculing in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Control of the conditions of the consequence of	Due to (or as a consequence of):    Due to (or as a consequence of):	Due to (or as a consequence of):    Due to (or as a consequence of):	Due to (or as a consequence of):  Due to	Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a	equentially list conditions sulting in death)  Due to (or as a consequence of):  Due to (or as a consequence	



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND IYEM#31 PER VITal records 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** ORIS 6.15 AM 4d. County of Death /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) Examiner ST RACTIMORE ONWA) If Under 24 Hrs. 8. 7. Age (In yrs, last birthday) If Under 1 Year 5. Social Security Number Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months 1 □ M 25 F 214-16-5805 Usuel Residence of Decedent Vrs -16-5805 Director TAY 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1₽ Yes 2 No Director N BUTIMORE 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 23a or USA W 21201 Hems : Was Decedant Evar in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status hours after 1 Yas 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 'natural', or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lite\_DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. College (1-4or 5+) MEAT Elementary/Secondary (0-12) ACKAGING MANUFACTORY 10 filed Demnit. Pages 1 and 2 should be file.
Department of Health and Mental Hygistrochart: if item 27 is marked any injury or other— 17. Father's Name (First, Middle Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be RANK ULLMAN HELEN 0 DORIG 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code)
3322 WooDSIDE AVE BATT, Md-21234 19a. Informant's Name/Reletionship (Type, Print) FRIGND ON4REDO, 20b. Place of Disposition (Nama of 20c. Location - City or Town, Stete 20a. Method of Disposition Date cematary, cramatory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) REMATOR 21. Signature of Fuheral Service Licensee DELLA NOCE Y FUNERAL HOME SONS S. HiCH ST. Balto, 2/202 Met. 234 Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death Physician /Medical Immediete Cause (Final disaase or condition resulting in death) Examiner Due to (or as a consequence of): Examiner Year (. C.A.D physician and the burief-fransit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medicai Dua to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yea 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s 1 Yes 2 No 1 Tyes 2 No certificate Division of Vital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of After 1 Natural 5 Pending death. 1 Yes 2 No To the Hospital or Attandit within 24 hours after death.

To the Funerst Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier edicai 🗷 Certifying Phyalcian: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 170 D44315 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) BALTIMORE 245 Street INCENto 6 RIPPO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 8 1999 Registrar **DHMH 16 Rev 6/95** 

ORIGINAL



Baitimore, Maryland 21215-0020

Box 68760.

P.O.

Records.

of Vital

Division

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** 4, 1999 **JOSEPH** JOHN SAUNDERS JULY 1540 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 5723 ONNEN ROAD BALTIMORE CITY N/A If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1X M 2□ F Yes AUG. 9, 1925 Director 220-14-0826 73 MARYLAND Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☑ Yas 2 ☐ No Director MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zio Code 10c. Citizen of What Country? ò Nerns 23s 5723 ONNEN ROAD 21206 U. S. A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Giva 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, Whita, atc. filed within 72 hours after 1 Naver Married 2 ☐ Married ò 1 ☐ Yes 2 ☐ No Specify: Specify. WHITE à 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8TH GRADE SHEET METAL MAINTENANCE MANUFACTURING COMPANY permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic event page. 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be GEORGE H. SAUNDERS ANNA V. REINSFELDER 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) CHARLES SAUNDERS (BROTHER) 3101 MORELAND AVENUE, BALTIMORE, MD. 21234 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Othar (Specify) PARKWOOD CEMETERY 7/13/99 BALTIMORE, MARYLAND 21. Signature of Funeral Sarvice Lidensee 22. Nama end Addrass of Facility SCHIMUNEK FUNERAL HOME INC. 3331 BREHMS LANE, BALTIMORE, MARYLAND 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immedieta Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Causa (Diseese or Injury thet initiated evants rasulting in death) Last Due to (or as a consequence of) Physician/Medical the Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by The law requires 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed INSPECTION page 1 Yas 2 XIXIO 1 Yas 2 No 25. Was case retarred to medical examinar? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) Certification: To MYas 2□ No this 27. Mannar of Death 28a. Deta of Injury (Month, Day Year) 28d. Describe how injury occurred After t Injury at Work? or Attending Natural 5 Panding invastigation n 24 hours after death. He Funeral Director: A bletely filled in by the fi death. 2 Accident 1 Yas 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be datarmined 3 Suicida 28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida Hospital 29a. Certifian 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end menner es stated.

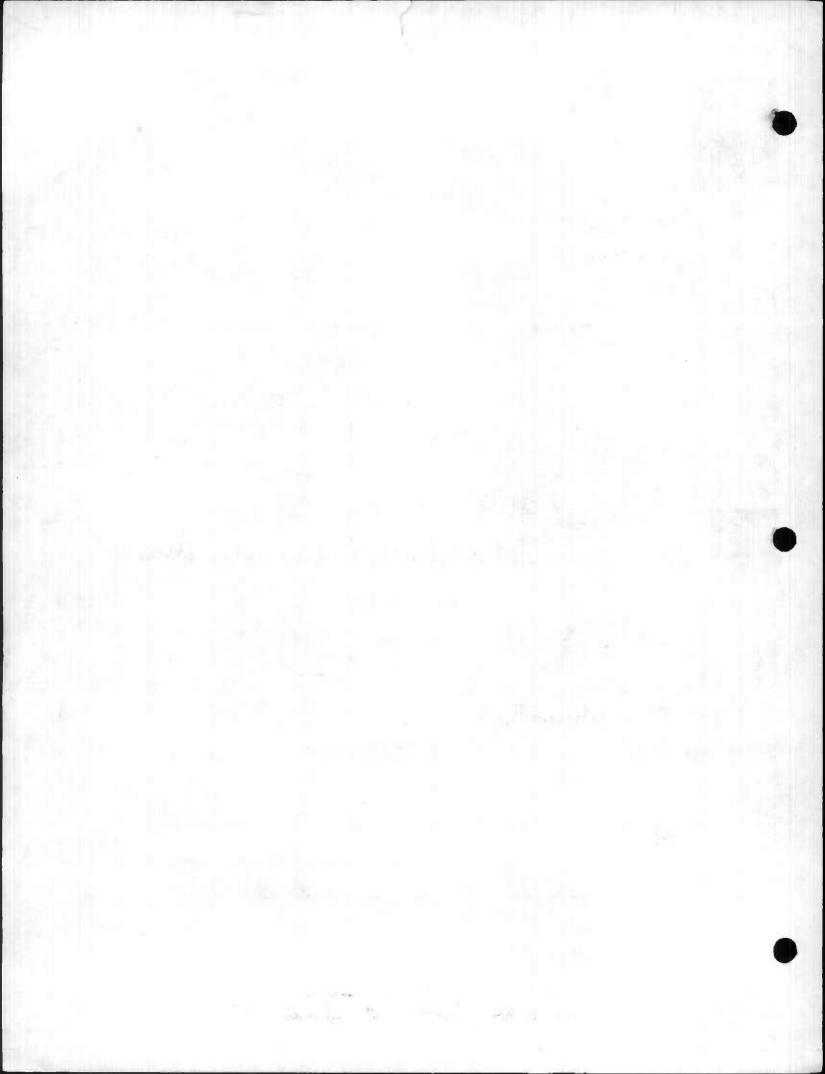
\*\*Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edicai To the Hosp within 24 hor To the Fune completely fi (Check only 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier OCME JULY 5, 1999 and iddrass of person who completed causa of deeth (Item 23a) (Type, Print) ARON witt 111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Data filed (Month, Day, Year)

32. Registrar's Signatura

8 1999

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Daath **Physician** Month 6:05 Am /Medical 4e. Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daeth 4c. County of Daath **Examiner** Catonsville Elder Care atonsville BAltimore If Under 1 Year | if Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplaca (State or Foreign Country) **Funeral** Months Days Hours 10 M 2□ F 217-14-2382 Yrs. Director Usual Rasidance of Dacedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 Vas 2 No NA Baltimore Director 10e. Street and Numbar 10f. Zip Coda 10g. Citizen of What Country? 6 2/229 or items 23a 000 ane U.S.A Funerai 12. Was Decedant Ever in U,S. Armed Forcas? 1 ☑ Yas 2 ☐ No If Yes, Give 13. Wes Decedent of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 11. Merital Status 14. Raca - Amarican Indien, Bleck, Whita, atc. 1 Naver Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No þ B/ack 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT usa ratirad) 16b. Kind of Businass/Industry Department of Health and Mentel Hygiane. Important: if item 27 Is marked other than any injury or other traumatic event, its Mo Elementary/Sacondary (0-12) Collaga (1-4or 5+) 24 COOK NA grade 17. Fathar's Name (First, Middla, Last). 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stete, Zip Code) Jauce Smith Baltimore 1000 COOKS 20b. Place of Disposition (Nema of cematery, crametory or other place) Method of Disposition Data 20c. Location - City or Town, Steta 1 B 2 □ Cramation 3 □ Removal from Stata 5 Othar (Specify) Funaral Sarvice Licans wabash Ba HU, MA 3 00 Luenne Enter the disaasa, or complications that causad the death. Do not antar tha mode of dying, such as cardiac or raspiretory errast, or leart feilura. List only one ceusa on each lina. Approximata Interval Betwaan Onsat and Death **Physician** /Medical disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, laading to immadiata ceusa. Enter Underlying Causa (Disaasa or Injury thet initieted evants rasulting in death) Lest Records, P.O. Box 68760 Physician/Medicai Part II. Other significant conditions contributing to death but not rasulting in the undarlying causa given in Pert I. 23b. Did tobacco use contributs to the cause of death? signed by t 1 ☐ Yss 2 ☐ No 3 Probably 4 Unknown ģ page 2 should b 24b. Were autopsy findings eveilable prior to Be Completed 24a. Was an autopsy performed? complation of causa of daeth? this certificate has Nonw 1 ☐ Yas 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica complately filled in by the funeral director, t 25. Was casa rafarred to madical axaminar? 28. Placa of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 ☐ Rasidanca 8 ☐ Othar (Specify) Certification: To 1 Yas 27. Manner of Death 28c. Injury at Work? 28b. Tima of 28d. Dascribe how injury occurred 1 Natural 5 Panding 1 ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not ba datarmined 3 ☐ Suicida 28a. Plece of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida Medicai 29a, Cartifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, date end pleca, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, deeth occurred et tha time, deta end pleca, and dua to the cause(s) and manner statad. 29b. Signetura and titla of certifiar 29d. Data signed (Month, Day, Year) 29c. Licansa number 30. Nama and addrass of parson who completed cause of death (Item 23e) (Type, Print) 01

State Registrar

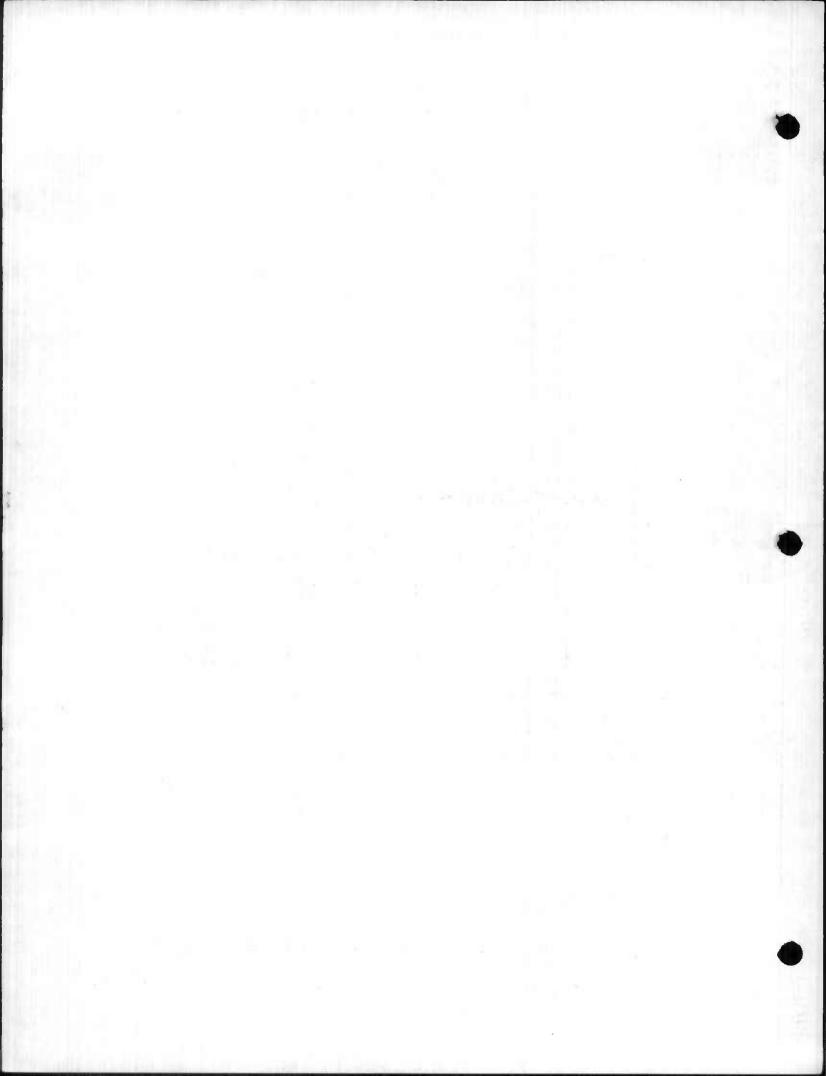
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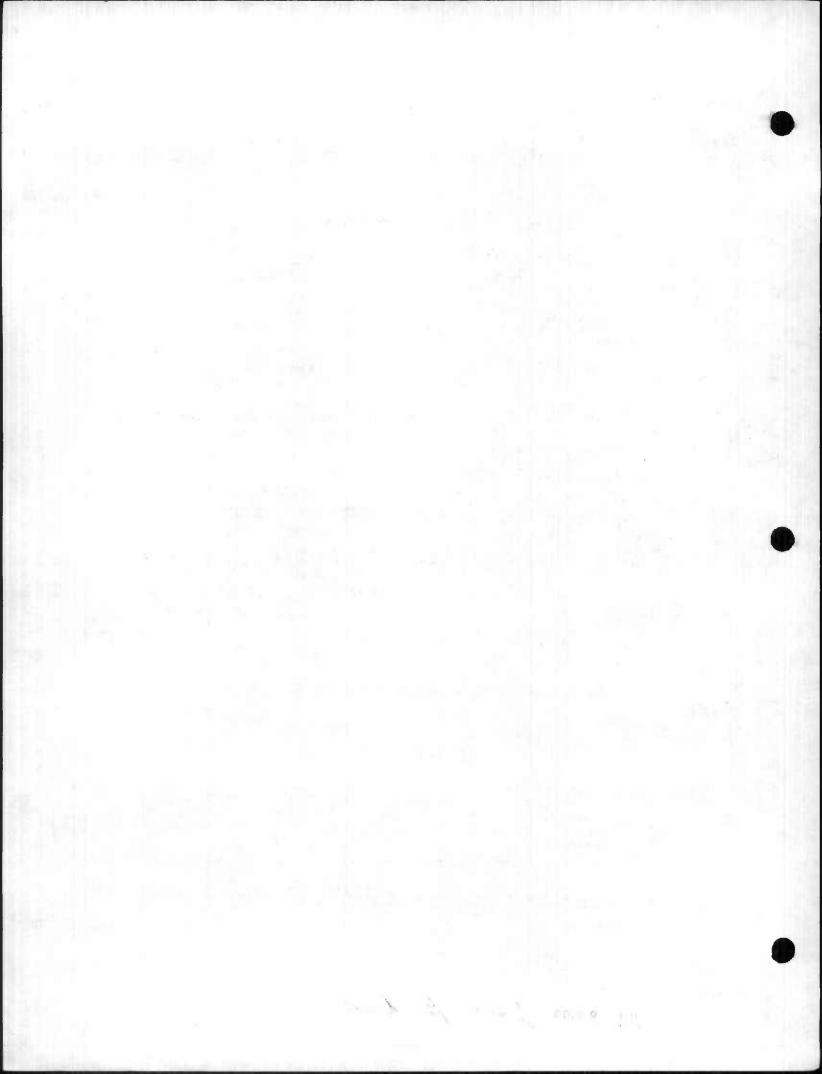
1999

32. Registrar's Signature



## Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

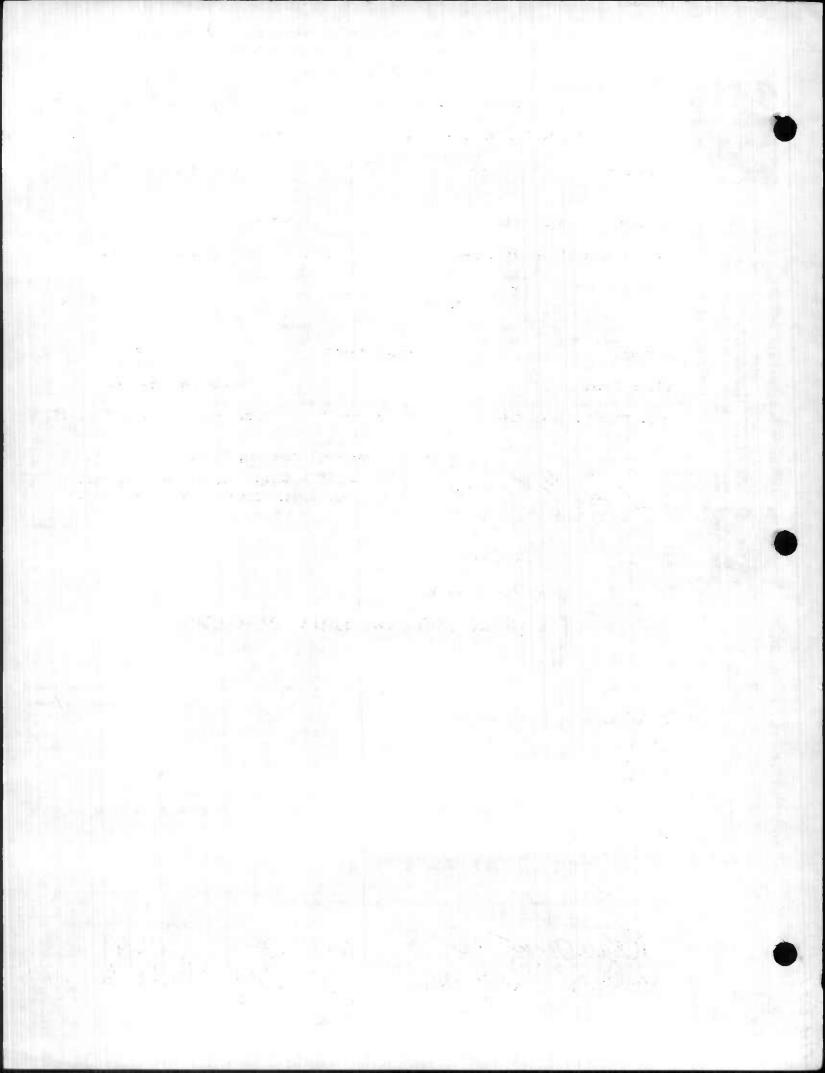
	Certificate of Death		g. No. 99 2	21479				
Physician	1. Decedent's Name (First, Middla, Last) Herman D. Sinclait	2. Data of Death Month	Day Year	3. Time of Death				
/Medical	Herman D. SINCLAR  4a Facility Nama (If not institution, give street and number)  4b. City, Town, or Lo	07-04-		7:00 AM.				
Examiner	0015		4c. County of Death					
<u> </u>				N/A				
Funeral Director	5. Social Security Number 215 60 7302  6. Sex 129 M 2 F 7. Age (In yrs. last birthday) 47 Yrs.  6. Sex 47 Yrs.  6. Sex 47 Yrs.  6. Sex 47 Yrs.  6. Sex 47 Yrs.  6. Sex 47 H Under 1 Year Months Days Hours Min.	8. Data of Birth (Month, Day, 12-10-	Year) 9. Birth Cou	place (State or Foreign ntry) MD				
Page 8 mg	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits				
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vith the Ma to r 28s-f a be notified Director	10a. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	ntrv?				
3a or	3017 GWYNN FALLS PKWY 21216		USA					
offer death v	11 Marital Status 12. Was Decedent Evar in U.S. 13. Was Decedent of Hispanic Origin? (Spe	city Yes or No-	14. Race - Ameri					
by Fr.	Armed Forces?  1 Never Merried 2 Married 1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No  1 Yes 2 No Specify:	Rican, etc.)	Black, Whita,	BLACK				
2 ho	15. Decedent's Education 16a. Decedent's Usual Occupation	10	6b. Kind of Business/In	ndustry				
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	11 LABORER		CONSTRUCT	TION				
Be distriction	17. Father's Name (First, Middle, Last)  18. Mother's Name		aiden Sumame)					
Vial Mente Mente of the office	ANDREW MOORE SARAH SU	JTTON						
Mar nd 2 sh lith and 27 is m r traum	19a. Informant's Name/Relationship (Type, Print) GLORIA CHAFFIN/SISTER  19b. Mailing Address (Street and Number or Rura 4550 CHAUCER WAY OWIN							
demit. Pages I ar bepartment of Nea reportant: If Nam ; my injury or other ince.	20a. Method of Disposition  1	Date 20 /10/99 B	Oc. Location - City or T	own, Stata				
information "	21. Signature of Funeral Service Licensee 22. Nama and Address of Fecility	10/ ) )	ALIO., FID					
D See 1	JAMES A. MORTON & S	SONS F.H	TNC					
	23a Part, Enjej the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac of heart fellure. List only one cause on each line.	LTIMORE	MD. 2121	7				
	shock of heart feilure. List only one cause on each line.	r respiretory erres	51,	Approximate Interval Between Onset and Death				
Physician / /Medical	Immediate Cause (Final	1.0	1	Onsor and Doarn				
Examiner	disease or condition resulting In death) a.	1aul	ure					
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and al-tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury thet initiated events  Due to (or as a consequence of):  Syndram  Due to (or as a consequence of):							
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rect Am rect of the by	3 Suicida 6 Could not be determined 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	eet and Number or Rur State)	ral Route Number,				
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To the Heaptal or Attanding Ph within 24 hours after death. completely filled in by the funeral Medical Certification: ]	29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred and menner steted.	and due to the cau ad at the time, dat	use(s) and manner as s te and place, and due t	stated. to the cause(s)				
Withir To th	29b. Signature end title of certifier 29c. License number	29	d. Date signed (Month,	Day, Year)				
	1 Surhara 121649		Tuly 7	1999				
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  D. S. Baskaran, 3455-Wilkous Are Bu	04	10 MD	2122 8				
		KIMO	4 / 10	-(20)				
State Registrar	31. Date filed (Month, Day, Year)  32. Registrar's Signature							



State of Maryland / Department of Health and Mental Hygiene 9

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Physician / Medical	1. 0	Decedent's Name (First, Middle	e, Last)	Nevi	n Le	eslie	Teal				2. Date of De Month 7 -	Day 6	Year 99	3. Tin	24 AN
Examiner		Facility Name (If not institution Johns Hopkins	-			Ctr.				wn, or Loc Limor	cation of Dear	th 4c. Cour	nty of Death	N,	'A
Funeral Director	2	Social Security Number	6. Sex 1 □√	M 2□ F	7. Age (In yrs	. last birthdaj Yrs.	y) If Undo Months	Days		24 Hrs. Min.	8. Date of Birth (Month, Day, Year) April 30,1929  9. Birthplace (State or Fo Country) Maryland				
<b>*</b> _	-	ual Residence of Decedent  a. Sfate 10b. County	_		10c, C	ity, Town or I	Location						1	Od. Insid	le City Lim
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or 28a-f show be notified at Director	106	Street and Number	Bait	imore			10f. Z	ip Code	Duna	IdIK	т Т	10g. Citizen o	f What Cour	nfrv?	
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must ment eral	11	41 Shipping P. Mantel Status			edent Ever in t	J.S. 13	Was Dec			nin? (Spe	cify Yes or N		ace - Americ		n.
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7 is marked traumatice TO E		a. Informant's Name/Relationsl		e. Print)		19b. Ma	ilina Addre	ss (Stree	t and Numbe	or or Rura	l Route Numl	per, City or Tow	m. State. Ziz	Code)	
TO CHI IN		Mrs. Edna L.					Shipp	ing			B-14	Dunda.	lk, MD	21	222
520	20a	Method of Disposition     □ Buriai 2 □ Cremation     4 □ Donation 5 □ Other (Sp.		moval from	State	cemetery, cr	ematory or	other pla		neter	Date Ty 7/9/	99 Ba			
Department of important: If any injury or once.	21.	Signature of Funded Service	Liconae	1	7//							of Dund			)
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nding physician and use as the buriel-transit	Serif a ceu	quentially list conditions, ny, leading to immediate use. Enter Underfying use (Disease or injury t initialed evants	<b>f</b> b.	gai	yren	or as a cons or as a cons		):							
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in 24 hours effer deeth.  The Furneral Director: Affer this certificate has been signed by the attending pletely filled in by the funeral director, page 2 should be detached for use pletely filled in by the funeral director. To Be Completed by Physician/M	25. 27. 29e	Was cese referred to medical examiner?  1   Yes   2   No    Mannar of Death   1   Natural   1   Natural   1   Natural   2   Accident   3   Suicide   4   Homicida   Certifyin   2   Medical     Medical   1   Medica	ggation not be ined	spital: 1 □ 28e. Date (Mon 28e. Place build)	Inpatient 2[ of injury th, Day Year) of Injury - At I ng, atc. (Spec	ER/Outpati 28b. Time Injury nome, farm, s	underlying  tent 3 0  of  M  sfreef, factor  ath occurre invastigation	causa g	26. Place ther: 4 Nu	of Death rsing Hor	23b. Dic  1 24a. Wa- peri  1 1 Check only  na 5 Ras 28d. Describe  28f. Location City or To	I tobacco use of the same autopsy ormed?  Yas 2/2 No one) idence 6 Co how injury occ (Street and Num, State) a causa(s) and data and place	24b. Way occord of 11	lera autoraliable pompletion death?  Yas  fy)  al Route stated, o the cau	psy finding rior to a of cause 2 No
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fer this certificate has been signed by the attending uneral director, page 2 should be detached for use on: To Be Completed by Physician/M	25. 27. 29c	Was cese referred to medical examiner?  1   Yes   2   No    Mannar of Death   1   Natural   1   Natural   1   Natural   2   Accident   3   Suicide   4   Homicida   Certifyin   2   Medical     Medical   1   Medica	ggation not be ined	spital: 1 □ 28e. Date (Mon 28e. Place build)	Inpatient 2[ of injury th, Day Year) e of Injury - At I ing, atc. (Spec best of my kn asis of examin ner stated.	ER/Outpati 28b. Time Injury nome, farm, s	underlying  tent 3 0  of  M  sfreef, factor ath occurre invastigatio	causa g	26. Place ther: 4 Nu	of Death rsing Hor	23b. Dic  1 24a. Wa- peri  1 1 Check only  na 5 Ras 28d. Describe  28f. Location City or To	I tobacco use of the same autopsy ormed?  Yas 2/2 No one) idence 6 Co how injury occ (Street and Num, State) a causa(s) and data and place	24b. Way occord of 11	lera autoraliable pompletion death?  Yas  fy)  al Route stated, o the cau	psy findirior to a of caus 2 No



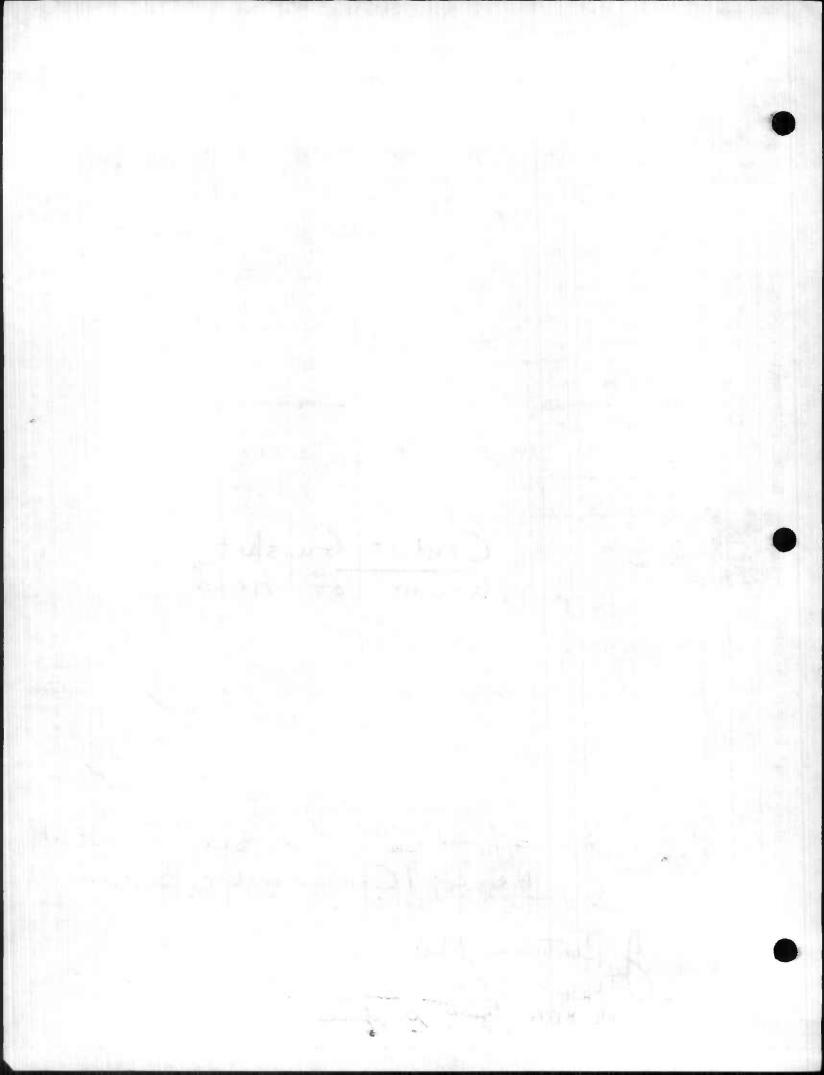
State of Maryland /	Department of	Health and I	Mental Hygiene

ROBER.	r A.			Ce	rtificate of	Death		Reg. No.	9 ;	21481		
Phy	sician	Decedent's Name (First, Middle, Las     ROBERT A	valenti				2. Date of De Month	Day	Year	3. Time of Death 2205 PM		
*		4e Fscility Neme (If not institution, give	street end number)			4b. City, Town, or L			y of Death			
		1 CINNAMON CIRC			Williams & Vana	RANDALLS		BALT				
Fune Direct	_		7	Yrs. last birthdey) Yrs.	Months Deys	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Pa Dec • 10	) 1946	Cour	ntry)		
fand		Usual Residence of Decedent  10a. Stete 10b. County	10c.	City, Town or Lo	cation				1	IOd. Inside City Limits		
o Man	ctor	Md. Balti	more		Ran	ndallstown	1			1 ☐ Yes 2 No		
death with the Marylan rine 23e or 28e-f show rines the notified at		1 0e. Street end Number 1 Cinnamon Cir	210		10f. Zip Code	21133		10g. Citizen of		ntry?		
feath w	neral	11. Meritel Stefus	12, Was Decedent Ever in	n U,S.   13.	Wes Decedent of H	ZIIJJ Hispanic Ongin? (Sp an, Mexican, Puerto	ecify Yes or No	- 14. Ra	ce - Americ			
_ o # #	by Fur	1 ☐ Never Married 2 ☐ Merried 3 ☐ Widowed 4 🂢 Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		f Yes, specify Cub 1 ☐ Yes 2 ☐ No		Rican, etc.)	Specia	ck, White, y: \			
Maryland 21215-0020 62 should be filled within 72 hours at his and Mental Hyglene. The marked other than "natural", or harmstic event, the Medical Franch	poletely filled in by the funeral director, page 2 should be detached for use as the burial-transit and a page 2 should be detached for use as the burial-transit and a page 2 should be detached for use as the burial-transit and a page 2 should be detached for use as the burial-transit and a page 2 should be detached for use as the burial-transit and a page 2 should be detached for use as the burial-transit and a page 2 should be detached for use as the burial-transit and a page 2 should be detached for use as the burial-transit and a page 2 should be detached for use as the burial-transit and a page 2 should be detached for use as the burial-transit and a page 2 should be detached for use as the burial-transit and a page 2 should be detached for use as the burial-transit and a page 2 should be detached for use as the burial-transit and a page 2 should be detached for use as the burial-transit and a page 2 should be detached for use as the burial-transit and a page 3 should be detached for use as the burial-transit and a page 3 should be detached for use as the burial-transit and a page 3 should be detached for use as the burial-transit and a page 3 should be detached for use as the burial-transit and a page 3 should be detached for use as the burial-transit and a page 3 should be detached for use as the burial-transit and a page 3 should be detached for use as the burial-transit and a page 3 should be detached for use as the burial-transit and a page 3 should be detached for use as the burial-transit and a page 3 should be detached for use as the burial-transit and a page 3 should be detached for use as the burial-transit and a page 3 should be detached for use as the burial-transit and a page 3 should be detached for use as the burial-transit and a page 3 should be detached for use as the burial-transit and a page 3 should be detached for use as the burial-transit and a page 3 should be detached for use as the burial-transit and a page 3 should be detached for use as the burial-transit and a page 3 should be d	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a. Deced	lent's Usual Occup	pation during most of work d)	ina	16b. Kind of B	usiness/Inc	dustry		
within the Man	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)		00 NOT use relire ntenance	d)		Social	Soci	Birthplace (State or Foreig Country)  Maryland  10d. Inside City Limits  1  Yes 20 No  1 Country?  American Indien,  White  ess/Industry  Security  te, Zip Code)  221  y or Town, Stata		
Di Hygi		17. Father's Name (First, Middle, Last)		Hali	rcenance	18. Mother's Nam	e (First, Middle		-	штоу		
ylan ylan ylantal Mental erkad c		Rosario R Vale	nti			Loret	ta Thac	cker				
Mar 52 sh h and r le m		19e. Informant's Name/Relationship (7) Sharon Jungblut			Riversic	end Number or Rui		er, City or Town		Code)		
- 유명하는		20a. Method of Disposition	·	b. Place of Dispo	sition (Neme of	1	Date			own, Stata		
Baltimore, smit. Pages 1 a beartment of He montant: If Item		1 ☐ Burial 2 ☐ Cremetion 3 ☐ I 4 ☐ Donetion 5 ☐ Other (Specify,			netory or other pla rematory	Inc. 7/2	2/99	Baltin	nore 1	Md.		
Salt semit. spart reports	đ	21. Signature of Funeral Service Licens	990	22	Name end Addre		Howa ad	F				
m goss	8	8. Terry	Connelle	1	300 Mace	Funeral Ave. Bal	HOME OF	Md. 212	221			
Physicia	20	23a. Part1. Enter the disease, or composhock, or heert feilura. List only of	lications that caused lime one ceuse on each lime	Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory a	rrest,		Approximete Interval Between Onset and Death		
/Medic	al	Immediate Cause (Finei disease or condition	('	ontac	of G	-unst	wt		1			
Examin		resulting In death)	DUB 10	O (OI as a consec			1 1	7	1			
ned I	ala e		b. We	und	8	+ 1	Rad	<	1			
68760, directe be execut physician and as the burial-trans.		Sequenfially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to	o (or as a consec	uence or):							
68760, ficate be ex	dica	that initiefed events resulting in death) Last	cDue to	o (or as a conseq	uence of):							
- D -	-		d									
death cer death cer e attendir	ICIar	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause give	ven in Part I	23h. Did	tobacco usa cr	ontribute to	o the cause of death'		
P.O. at the d by the elached	Phys			. counting in the di	identyllig deduce gr	TOTAL TOTAL		Yes 2 No				
dS, P ires that signed b	by								Tash W	less autonou findings		
Records, ne law requires ti e has been signe	letec							an eutopsy ormed?	av	reilable prior to empletion of cause		
	ошо	3174					109	Yes 2□No		Yas 2 No		
Vital I	BeC	25. Was case referred to medical examiner?				26. Place of Deal	th (Check only	one)				
- 5 00		XX Yes 2 No 27. Manner of Death		ER/Outpatier	1 3LI DON		6.5	dence 8 □Ot		(y)		
ding P. Atter	tlon	1 Natural 5 Pending 2 Accident investigation	Month, Dey Year	MEL	round Wo	ryat rk?  Yes 2.52√No	Sad. Describe	how injury occu	Sh	otself		
Division  or Attending after death.  Director: After d in by the fune	Iffica	Suicide 6 Could not be determined	28e. Place of Injury - A	2016 If home, farm, str			28f. Location /	Street and Num	ber or Rura	al Route Number,		
D safe in in in in in in in in in in in in in	Cert	4 Difficulties	Home C	· 1	_inn	amon	City or To	: 13a	Hen	rore, Md		
Hospital 24 hours Funeral stely filled	dical		sician: To the best of my iner: On the basis of exam									
To the Hospital within 24 hours: To the Funeral completely filled	Me	29b. Signefure and title of certifier	and manner stated.	. ^	29c. Licens	se number		29d. Date signe	ed (Month,	Day, Year)		
FSFO		14 Rut	ann N	1.D.	0	.C.M.E		JULY	2, 19	999		
		30. Name and address of person who co	ompleted cause of death (I			Deltim		-13 01	201	- JEEP		
		170500	1 Vestaner	TII Penr	street,	Baltimor	e, mary	Tana 21	.201			

State Registrar

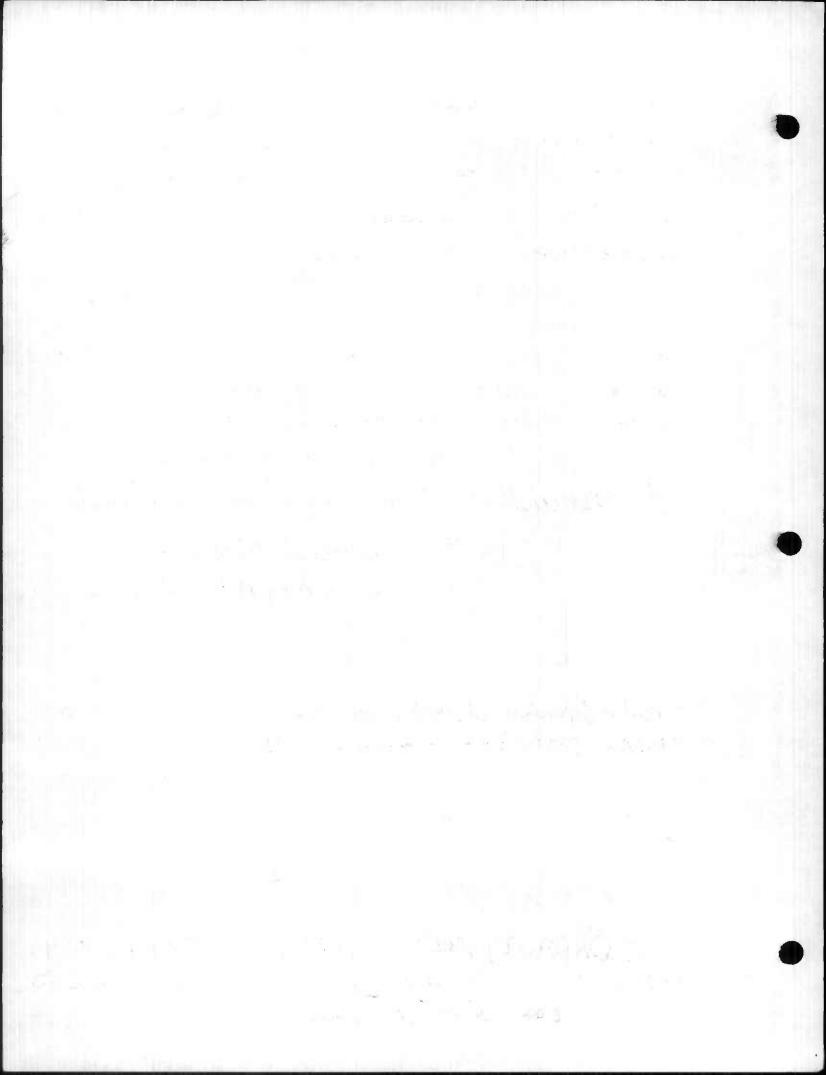
8 1999 DHMH 16 Rev 6/95

31. Dete filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

					, ,	C	ertificate of	f D		iornai riy	Reg. No.	00	21485
	Dhyoloi		Decedent's Nama (First, Middle, Lateral	•						2. Data of De Month		Year	3. Tima of Death
	Physici /Medic		David	W	alke	er				June	30,	99	10:00am
	Examir	ner	4e. Facility Nama (If not institution, give	and the same of th	_				o. City, Town, or Lo		4c. Count	y of Death	
L			Union Memoria  5. Social Sacurity Number 6. S			4 6 7 46 .4.	If Under 1 Yea		altimor		NA		
e.	Funeral Director		240-05-9554	36 D =	a (In yrs. I 83	ast birthda Yrs.	Months Day		Hours Min.	8. Date of Bir (Month, Da			placa (Stata or Foreign ntry) VC
	land		Usual Residanca of Dacedant  10e. Stata 10b. County		10c. City	, Town or	Location			·			10d. Insida City Limits
	n the Meryland r 28a-f show	tor	MD NA		Ва	ltin	nore						Mas 2□No
	r 28e	Irec	10e. Street and Number				10f. Zip Coda	a			10g. Citizan of	Whet Cou	ntry?
	23a c	alD	2715 The Alam	eda			212	218	8		USA		
0700-0	hours after death with the Meryland tural', or items 23s or 28s-f show at Examiner must be not ind at	by Funeral Director	11. Marital Status  1 Navar Married 2 Married  3 Widowed 4 Divorcad	12. Was Decedant Armad Forcas?  XXX Yas 2 1 N If Yas, Giva Yaar or Datas:		S. 1	3. Was Decedant of If Yes, specify Cu 1 ☐ Yas 2 ☒ No			ecify Yas or No Rican, atc.)		ce - Americk, White,	
5	72 hours "natural".		15. Decedant's Ed	ucation		16a. De	cedent's Usuel Occi	upat	tion		16b. Kind of B	usinass/in	dustry
Z	within 7	Completed	(Specify only highast gra Elamantary/Secondary (0-12)	oa completad) Collega (1-4or 5	+)		cedent's Usuel Occi va kind of work don i. DO NOT usa ratir	na du ired)	inng most of works	ng			
V	Hygien Hygien ther th		Unknown	NA		Cus	stodian						Office
and	o da b	Be	17. Fathar's Nama (First, Middla, Last)						18. Mothar's Nama				
5	should b nd Menta marked imatic e	To	Edward 19a. Informant's Name/Relationship (7)	Walke	r	19h Ma	ailing Address (Straa	at at	Clidye		Mora		Code)
Z	The Trans			alker									nd 21218
e,	other		20a. Mathod of Disposition		20b. Pl	aca of Dis	sposition (Nama of ramatory or other pi			Dete	20c. Location		
	ant cant		★ Burial 2 Cramation 3 C 4 Donation 5 Other (Specify	Ramoval from Stata			at'l Cem	,	·	-09-99	Farmi	ingda	ale,NY
pallimor	permit. Pege Department of Important: If any injury or once.		21. Signetura of Funeral Servica Lican	saa	7	1	22. Neme and Add	Irass	of Facility Ba	ltimor	o Mar	-17] 27	nd 21202
D	80 = 9		B. Valone	in Hol	an	d	WM.C.Ma	r				_	
ľ			23e Fart1. Entar the disaasa, or comp shock, or heart failure. List only	plications that causad	the deeth	. Do not	antar the mode of dy	ylng,	, such es cardiec d	r raspiratory a	rrast,	LAV	Approximata Interval Between
	Physician		1-10-10-10-10-10-10-10-10-10-10-10-10-10	00	1	_ ^	A / A		1 1 -	P . 1			Onset end Death
	/Medical Examiner		Immadiata Cause (Final disaasa or condition rasulting in death)	a. 17C	Ule	1	MOCA	7	JIAI IV	MACT	100	1	
L		-		oth	Due to (or	as a cons	sequanca of):		2000	a.h.	die	200	
-	od d ansit	Examiner	Segmentially that penditions	b	Due to lo	CREA	saguanca of):	JA C	onary	Tr pers	) UIX	MAX	
Ś	en en	Exa	Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or Injury that initiated events		Dua to (or	a3 a con	aquance on.					1	
0/00,	icete be executed physicien end s the buriel-transit	edical	that initiated events rasulting in death) Last	C	Due to (or	as a cons	equance of):					-	
Š	± 0 0 0			d								- 1	
0	ettenc for us	slan											
5	the de	Physician/M	Part II. Other significant conditions of	A 1	1 4		1.1	- 1					o the cause of death?
-	thet ned by dete	by Ph	Insulin dependen				1 Noll			10	Yes 2□ No	3□ Pro	bably 4 Unknows
SCOURS,	To the Nospital or Attending Physician: The law requires that the death certificate be exectivith 24 hours after deeth.  To the Funeral Director: After this certificate hes been signed by the ettending physicien encompletely filled in by the funeral director, page 2 should be deteched for use as the buriel-transpace.	Completed b	Chronic Obs	shite	- 4	2/n	nonary	4	disease		an autopsy med?	av	ara autopsy findings railabla prior to implation of cause daath?
	The la	mo:								10	Yas 2 No	1[	□Yes 2XNo
2	Physician: The law this certificate hes al director, page 2	Be	25. Was casa rafarrad to medical axaminer?						26. Placa of Death	(Check only o	ona)		
5	hysic his ce	2	1 Yas 2 No	Hospital: 1 Inpatie	nt 290 E	R/Outpat	ient 3 DOA	Othar	4 ☐ Nursing Hor	na 5□Rasio	danca 6 Ott	nar (Specia	(y)
	ing P	inol.	27. Mannar of Death 1 Natural 5 □ Panding	28a. Data of Injur (Month, Day	Year)	28b. Tima Injun	W	Jork?	?	28d. Dascribe I	how Injury occur	rred	
2	deeth deeth stor: /	Icat	2 Accidant Invastigation 3 Suicida 6 Could not be		Inc. At hou	no form			as 2□No	Of Location (	Street and Num	har or Pur	al Routa Number,
2	after Direction of the property of the propert	Certification:	4 ☐ Homicide determined	building, etc	. (Specify	)	straat, factory, office	a	(	City or Tov	vn, Stata)	oer or nure	ii nodia Ndiliber,
	To the Hospital or Attending Physician: within 24 hours after deeth.  To the Funeral Director: After this certifica completely filled in by the funeral director,		29a. Cartifier 1 Cartifying Phy	valcian: To the best o	f my know	iadge, de	ath occurred at that	tima	, date and place, a	ind dua to tha	cause(s) and m	anner as s	stated.
	he He in 24 he Fu	edical	(Check only 2 Medical Exam	Iner: On the basis of and mannar sta	axaminati	on and/or	investigation, in my	opii	nion, daath occurra	ad at the time,	data and placa,	and dua t	o the causa(s)
	vith To t	Σ	29b. Signatura and titla of certifier		A	$\wedge$	29c. Licar	nsa	number		29d. Data signe	ed (Month,	Day, Year)
t	/		· COKE	WY	[wy		LD.	2	7860		2714	131	1999
	6		30. Nama and addrass of person who could be strong to the country of the country	ompleted causa of de	ath (Itam	23a) (Tyn	e, Print) 700	V	UNSIL BI	UD B	PLT/	no	21230
	Sta Registr		31. Data filed (Month, Day, Yaa 1	32. Raginta	s Signat	No.	5. Loan	ut	2				



#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Month 12:30pm William WHIT 4c. County of Deeth 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 7A/b07 HOSP HO452 EAST ON A 1607 1 e E If Under 24 Hrs. Hours Min. If Under 1 Year 5. Sociel Security Number 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 6 Sax 1 X M 2 □ F Months Deys 60 May 12, 1939 Washington, DC 578-54-6335 Usual Residence of Deceden 10d. Inside City Limits 10a Stete 10b County 10c. City. Town or Location X□ Yes 2□ No Talbot Easton 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? 586 Cynwood Avenue 21601 USA 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 12. Wes Decedent Ever In U,S. Armed Forces? Bleck White etc Yes 2 No 1 Never Merried 2 Merried 1□Yes 2HNo Specify: Specify: White 3 Widowed 4 Divorced 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Sales Automotive 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) William Franklin White, Sr. Gertrude Schmidt 19a. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Wendy Lennon/Daughter 111 Paris Lane, Easton, MD 21601 20e. Method of Disposition 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 🕅 Cremetion 3 ☐ Removel from State Baltimore Washington Cr. 7/8/99 Laurel, Maryland Donetion 5 Other (Specify) Co Licen 22. Neme end Address of Fecility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 or the mode of dying, such as cardiac or respiratory arrest, Approximate divises, or complications that caused the death. Do not enter the mode of dying, such as cardiac allum. List only one cause on each line. Approximate Intervel Between Onset end Deeth ASTROCYTOMA Due to (or its e consequence of): Immediate Ceuse (Final morTAS disease or condition resulting In deeth) Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other stanificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings avelleble prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical exeminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospin 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 TYes 2 □ No 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28t. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide

certificate be axecuted Box 68760. Division of Vital Records, P.O. or Attending Physician: after death. Director: Aft 24 hours a Funeral C Hospital To the F within 2 To the F

**Physician** 

- /Medical

Examiner

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**Funeral** 

**Director** 

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i Hygiene.

Pages 1 and 2 should be in nent of Health and Mental I int: If them 27 is marked of

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25 Department of Important: If any Injury or ance.

**Physician** 

/Medical

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Certification:

Medical

29a. Certifier

Ludwig

(Check only one)

29b. Signature and title of certifier

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death

filed within 72 hours after

Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Dey, Year, JUL 8 1999

J.

III MI) EgLSEdER 32. Registrer's Signature

30. Name and address of person was completed cause of death (flem 23a) (Type, Print)

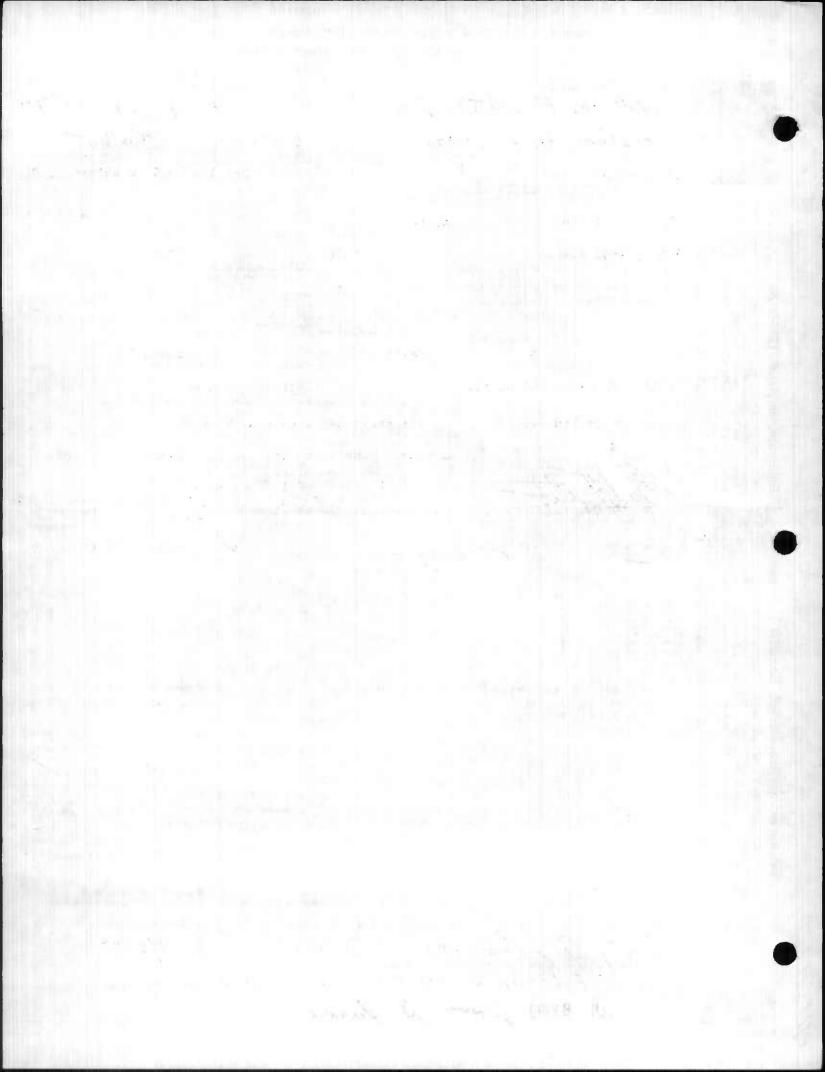
1🗹 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end pleca, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end menner steted.

29c. Licensa number

505-A DUTCHMONS LANG BASTON Md 21601

29d. Date signed (Month, Day, Year)



2. Dete of Deeth

3. Tima of Death

Physician /Medical	Zondra	Lee 1	Westwood						July 7	, 1999	Year	3:04 AM		
Examiner	4a Facility Neme (If not institution Franklin Squar						4b. City, To Ross		ocation of Deat		ity of Deeth			
Funeral Director	5. Social Security Number 218 44 0413	6. Sex 1 M 2 KF	7. Age (In yrs. last	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, De NOV • 2	th Y 1946	9. Birth Cou Mary	place (State or Foreign offry) Land		
Director	Usual Residence of Decedent 10a. State 10b. Count Maryland Balti	,	10c. City, T	own or Lo								10d. Inside City Limits 1 ☐ Yas 2 No		
23s or 28s-f s at be notified	10e. Street and Number 414 Mace Avenu	ae			10f. Zip	Code 2122	21			10g. Citizen o	What Cou USA	intry?		
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in and rial-transit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	b. MORB	ID OBES	ITY e conseq	uence of):						1	25 YEARS		

1. Decedent's Neme (First, Middle, Last)

25 YEARS Due to (or as a consequence of):

Part II. Other algnificant condition	s contril	buting to death but not n	esulting in the unde	erlying	caus	se given in Pert I.	23b. Dld to	^ -	ontributa to the cause of death?  3 Probably 4 Unknown
							24a. Was a perfor	n autopsy	24b. Were autopsy lindings available prior to completion of cause
							1 U Y	es 2⊠No	ol deeth?
25. Was case referred to medicel examiner?  1 ☐ Yes 2 ☒ No	Hos	pitel: 1 ☐ Inpatient 2	ER/Outpatient	3 🗆 (	DOA	Other	eth <i>(Check</i> only or Home 5 Resid		ner (Specify)
27. Manner of Death  1 Netural 5 Pending  2 Accident investig	tion	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 Yes 2 No	28d. Describe h	ow injury occu	rred
3 Suicide 6 Could r 4 Homicide	t be ed	28e. Plece of Injury - At building, etc. (Spec	home, lerm, street	, lecto	ory, o	ffice	28I. Location (S City or Tow	treet end Num n, State)	ber or Rurel Route Number,

29b. Signeture end title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

D.O.

H35593

JULY 7, 1999

30. Name and address of person who someleted ceuse of death (Item 23a) (Type, Print)

1124 MACE AVE., Baltimore, MD. 21221 LOH JOHN J. 31. Date liled (Month, Day, Year) 32. Registrar's Signature

State Registrar

Medical Certification: To Be Completed by Physician/Medical

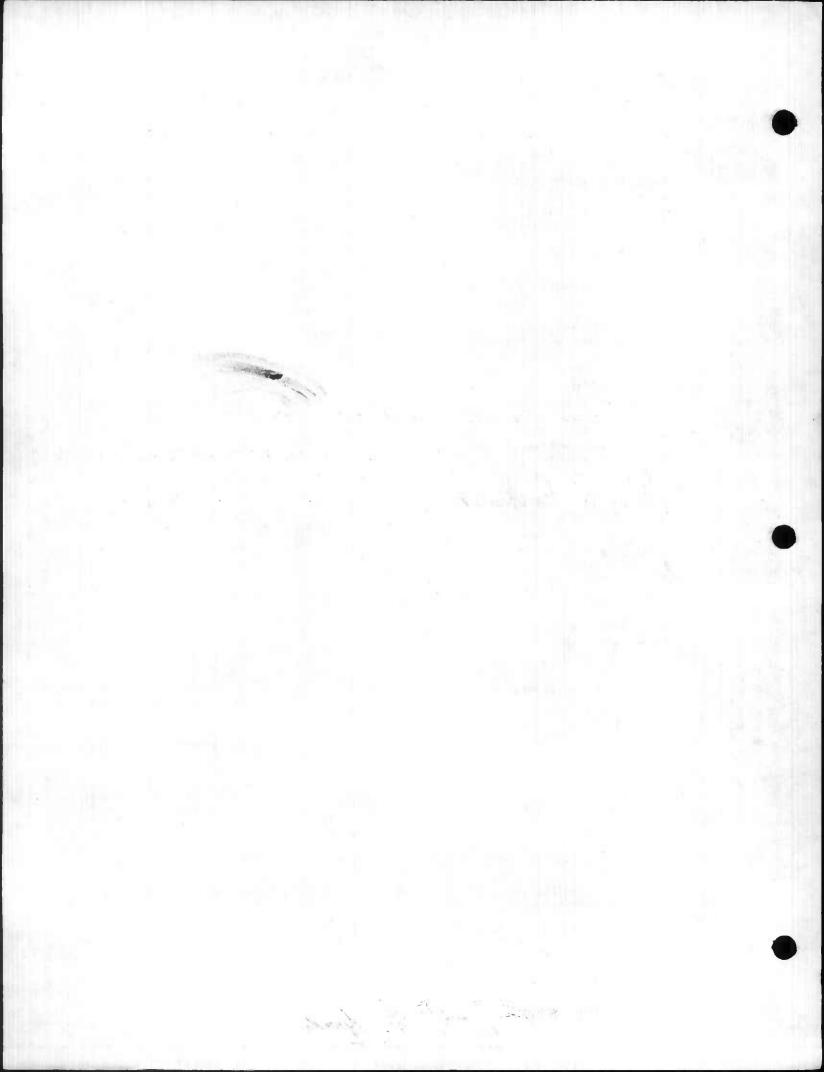
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**DHMH 16 Rev 6/95** 

24 hours after dea Funeral Director

Division of Vital Records, P.O. Box 6876

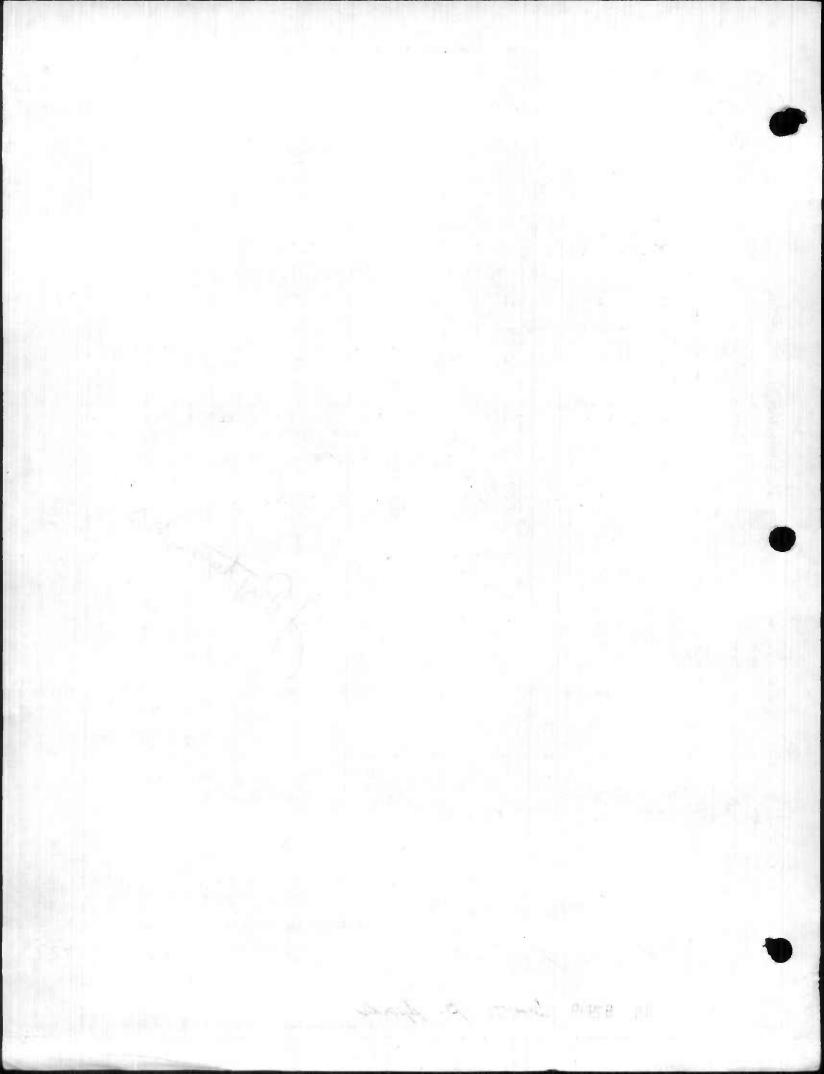
The law requires that the death certificate be



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene RepLACEMEN Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Veer 23, Allan R. Wetzler June 1999 4:22am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltimore Baltimore 5. Social Security Number 6. Sex 14 M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** Days Min. Months Hours 217-26-3198 92 AUG. 1, Director PA Usual Residence of Decedent 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes XX No BALTIMORE MD BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r 725 MT. WILSON LANE #406 21208 U.S.A. Funeral Barra. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married b Maryland 21215-0020 1 Yes 2 No Specify: WHITE Specify: à 3

Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "I Elementary/Secondery (0-12) College (1-4or 5+) PROPRIETOR LADIES READY TO WEAR 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) 80 LEO WETZLER ANNA WELDER 19a. informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT WETZLER / SON 6217 GLEN FALLS ROAD - REISTERSTOWN, MD 21136 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Stete 4 Donation 5 Other (Specify) 6/25/99 HAR SINAI CEMETERY OWINGS MILLS, MD 21. Signature of Funeral Service Lie 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** 32NV /Medical Immediete Cause (Final Pulmonary Embolus disease or condition resulting in death) 42 minutes Examiner Due to (or as a consequence of): Examiner Deep Vein Thrombosis Indeterminate physician and the bunal-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Right Hip Fracture 7 days Box 68760 Physician/Medical Due to (or as a consequence of): 98 980 6 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. Per Per á 1 Yes 2 No 3 Probably 4 Unknown signed t Records. þ Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to peed completion of cause of death? page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital director 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this funeral 27. Menner of Death Certification: 28b. Time of Injury 28a. Date of Injury (Month, Dev Year) 28c. Injury et Work? 28d. Describe how injury occurred After 1 Natural 5 Pending or Attending after death. Director: Aft 1 Yes 2 No 6/16/99 investigation 2 Accident Unknown Fe11 6 ☐ Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Home/Assisted Living - North Oaks Hospital 24 hours a 725 Mt. Wilson Lane 21208 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29e. Certifier Medical completely (Check only To the To the To the M 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vabian L. Paden, MD 2401 W. Belvedere Avenue Baltimore 21215 31. Dete filed (Month, Day, Yee JUL 91999 32. Registrar's Sonature State JUL Registrar

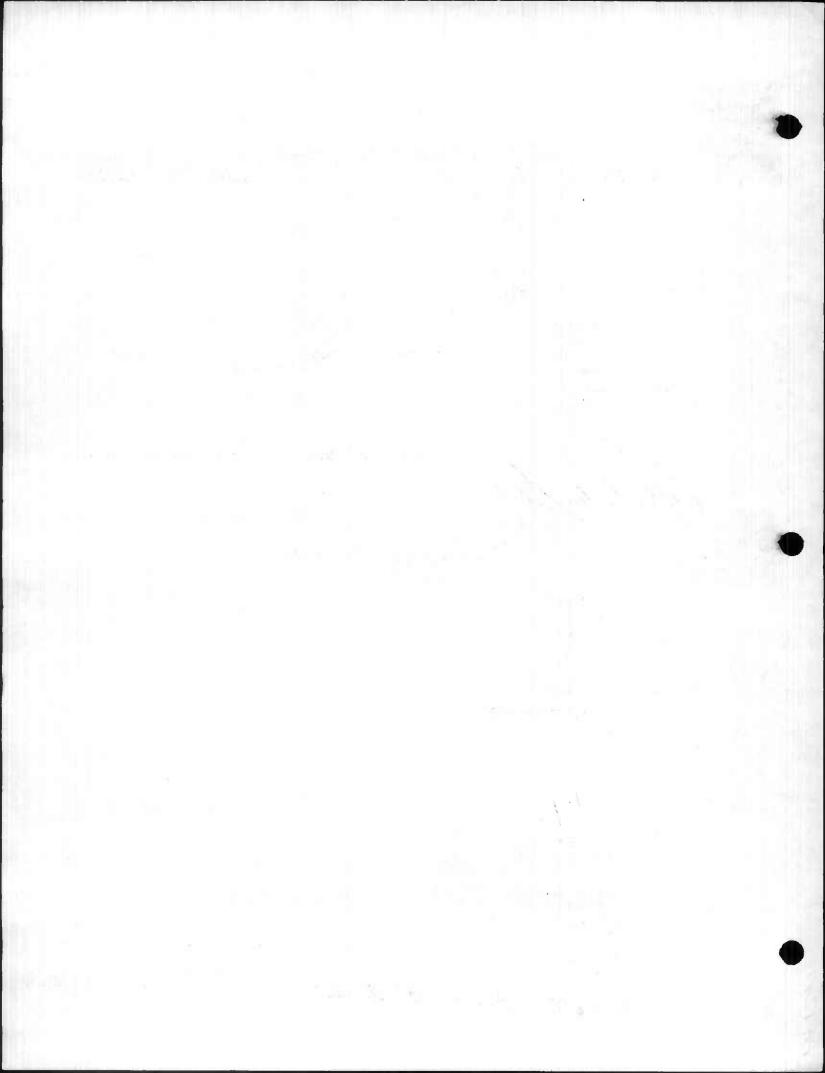


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					Ce	rtificat	e of	Death	7		Reg. No.			
Physici /Medi		Decedent's Name (First, Middle, L		le We	tzler					2. Date of De Month		Year	3. Time of Death 1:00 PM	
Examir		4a. Facility Name (If not institution, g	ive street and numbe	er)				4b. City, To	own, or Loc	cation of Deal	1	ty of Deeth		
		· 713 M	laiden Choice	Lane #1	412				Cato	nsville		Baltim	nore	
Funeral Director		5. Social Security Number 6. 216-01-5931 Usual Residence of Decedent	Sex 1□ M 2□ F	Age (In yrs. I		Months	1 Year Days	if Under Hours	r 24 Hrs. Min.	8. Date of Bi (Month, Di 08/09)	rth ey, Year) /1913	9. Birthpiac Country Maryl	ce (State or Foreig and	
tat		10a. State 10b. County		10c. City	, Town or L	ocation						10d	. Inside City Limit	
28a-f s	Director	Maryland B.	altimore	C	atons		0.1						1 ☐ Yes 2 ☐ N	
23s or		713 Maiden Choice L	ane #1412			10f. Zip	Code	21	228		10g. Citizen o	What Country U.S.A		
ral', or items 23e or 25e-f show Examiner must be notified at	by Funeral	11. Merital Status  1 ☑ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Wes Deceder Armed Force: 1 Let es 2 [ If Yes, Give Year or Dates	s? ] No		Was Deced If Yes, special 1 Yes	cify Cub	an, Mexicai	n, Puerto F	cify Yes or No Rican, etc.)	or No- 14. Raca - American Indian, Black, White, etc.  Specify: White			
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arited of	To	John Wetzler						Mar	y Aid	1t				
and is me		19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ing Address	(Street	end Numb	er or Rura	l Route Numb	er, City or Tow	n, State, Zip C	ode)	
em 27 ither tr		Mr. William Bracke	n			719 Cha	aring (	Cross B	altimor	e, Maryia	nd 21229			
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DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Edward Wasilewski, Sr. July 6, 1999 5:52 PM 4a. Facility Name (If not institution, giva streat and number) 4b. City, Town, or Location of Deeth 4c. County of Death 7609 Avondale Avenue Dundalk Baltimore If Under 1 Year Months Days 5. Social Sacurity Number II Undar 24 Hrs. 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 1☑M 2□F Yrs. 74 216-16-1380 March 5,1925 Maryland Usuel Residence of Decedent 10a. Stete 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2€ No Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21222 7609 Avondale Avenue United States 12. Was Decedent Ever In U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑ Yas 2 ☐ No It Yas, Give Year or Detes: WWII 1 Never Married 22 Married 1 ☐ Yas 2 ☐ No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highast grede complated) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 8 Years Brewery Worker Liquor Manufacturing 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Stanislav Wasilewski Alexandra Dosiak 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Regina Wasilewski/Wife Baltimore, MD 7609 Avondale Ave. 20b. Placa of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Facred Ht. of Mary Cem. 7/9/99 Dundalk, Maryland 21. Signature of Fo eral Service Licens 22. Nama and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Dundalk, Maryland 21222 Approximata Intervel Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in deeth) Due to (or es a consequence ot) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initiated events resulting in deeth) Lest Due to (or es a consequenca of) Due to (or as a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 000 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to 24a. Wes en eutopsy completion of cause of deeth? 2000 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only one)

**Physician** /Medical Examiner

physician

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**Physician** 

/Medicai

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**Funeral** 

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Pages 1 and 2 should be in nent of Health and Mental I ant: If Item 27 is marked or

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Department of Important: Meny injury or

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Director

Funeral

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Completed

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21215-0020

altimore, Maryland

the buriel-transit 8 director, page 2 should funeral

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

of Vital

Division

or Attending Physician:

Hospital 24 hours

Examiner Physician/Medical þ Completed Be 2 Certification: In by the

25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA

27. Manner of Deeth Netural 5 Pending Investigation 2 Accident

6 Could not be

28e. Date of Injury (Month, Day Year) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 28b. Time of

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier

3 Suicida

4 Homicide

the certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated.

29b. Signature and title of cartif

29c. License number

29d. Date signed (Month, Dey, Year)

30. Neme and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

Theodore Stevens MD 1005 N. Pt. Road Baltimore, Maryland

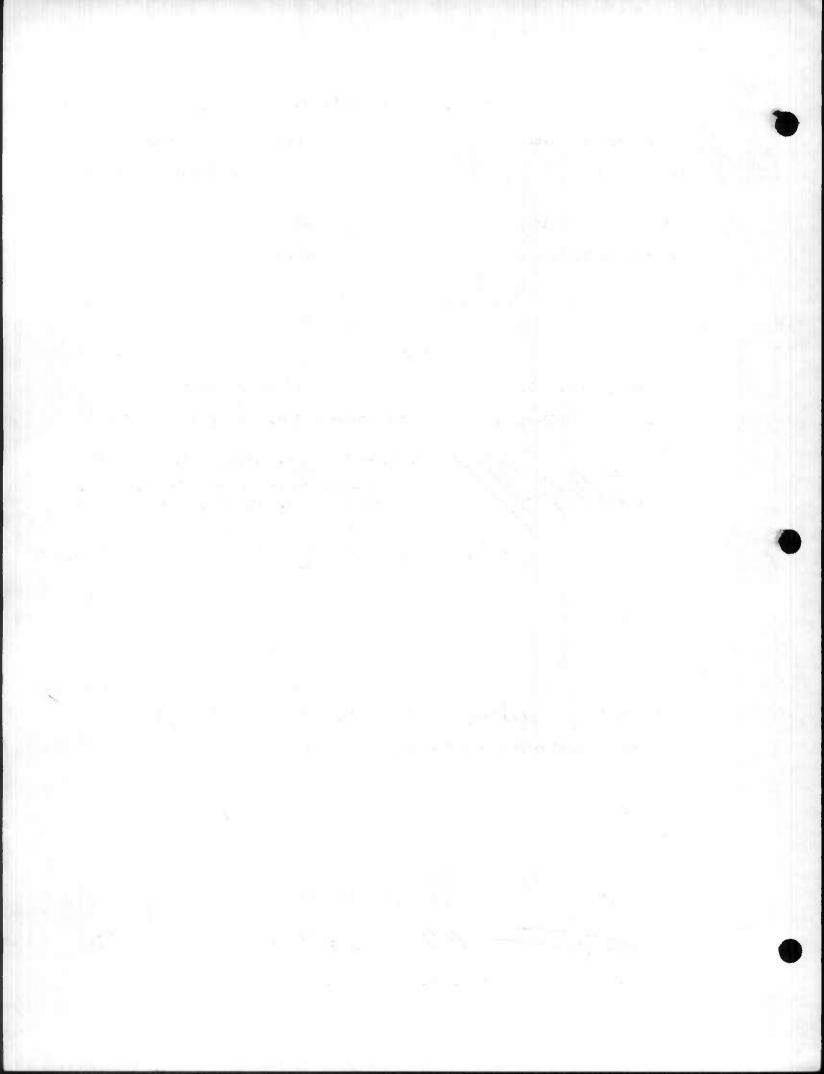
State Registrar

Medical

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Sparks



## Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 2 1 4 8 8

				Certificat	e of	Death		Re	g. No.	Sec.	1700
	sician	1. Decedent's Name (First, Middle, Last RUTH WAZLA						2. Date of Death	1	9 <sup>7</sup> 9 <sup>8</sup> 9	3. Time of Death  10:25PM
2/4	edical miner	4a Facility Name (If not institution, give 1620 JOPLIN ST				4b. City, To		cation of Death	4c. County		10.23FM
Fune Direc		5. Social Security Number 6. Se 215-24-1355  Usual Residence of Decedent	7. Age (In yrs.	Ast birthday   If Under   Months   Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Your) 7/29	9. Birthp Coun	lace (State or Foreign
-0020 hours after death with the Maryland urar!, or flems 23s or 28s-f show	Director	10a. Stata 10b. County		BALTO.						10	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
eath with the	Funeral Dire	10e. Street and Number  1620 Jopel  11. Marital Status	ST.  12. Was Decedent Ever in U.	10f. Zij	2	12	29		Og. Citizen of W	What Coun	1
Z1Z15-0020 d within 72 hours after dea giene. r then "natural", or frema	Ď	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	,S. 13. Was Dece If Yes, spe			Puerto F	Rican, etc.)		k, White,	
72 houn	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Decedent's Usu (Give kind of wo	rk done	during most	of workin	19	6b. Kind of Bu	siness/Ind	dustry
within then	idm	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT u		,	- 1 -		11.		_
	ပိ	17. Father's Neme (First, Middle, Last)	0	HO.	ni	18 Mothe		(First, Middle, N	laiden Sumam	MI	
E SEP	Be	1-11- 8								-	,
Maryis 12 should h end Mer 7 la marke	To	19a. Informant's Name/Relationship (T)	METZ S	19b. Mailing Address	: (Stree			I Boute Number			
Baltimore, permit. Pages 1 and Department of Health Important: if Item 27 env inlury or other 1		20a. Method of Disposition  1 Burial 2 Cremation 3 F  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens	Removal from State 20b. P. C. S. A. C.	Place of Disposition (Nacemetery, cremetory or control of the series of	ther plant of Address of A	JES ess of Facilit ews/	US 7	7-1-99 T.H.	BAL BAL	City or To	nID 2/3 wn, Stata , MD
		23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused the deat	h. Do not enfer the mod	le of dyi	ng, such as	cerdiac or	respiratory arre	est,	, h	Approximate
Physicia	an	shock, or heart failure. List only of	ne cause oweach line.							i	Onset and Death
/Medic	al	Immediate Cause (Final disease or condition	Chat.	melitie an	/	1 4 4/1	cono	Our 1	10-01-	14	Moria
Examin	er	resulting in death)	Due to (a	ras a consequence of):	/	melle	CHECK	July C	OVY		T W PA
D =	ě							U			
icata be assected physician and s the burlai-transit	i Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	or as a consequence of):		100					18
Centif	ž	that initiated events resulting in death) Last	Due to (or	r as a consequence of):						-	
deeth or	2	Part II. Other significant conditions cor	stributing to death but not rec	ulting in the underlying		ion in Dort I		22h Didto	hanna 1100 nan	ndelbuda de	the cause of pleath?
d by th	by Physician		in builing to coulin but NV 1654	oning in the uncertying c	ouse gi	VOIT HIT F GIZ ( ).		1/€ Ye		3 □ Prot	
aw requ	piete							24a. Was ar perform		BVE	ere autopsy tindings allable prior to mpletion of cause death?
- F # 8	S							1 ☐ Ye	s 212 No	t C	Yes 21 No
yelclan: The is certificate he director, page	B	25. Was case referred to medicat examiner?	lospital:				of Deeth	(Check only one	9)		
		1 Yes 2⊠ No		ER/Outpatient 3 DO	)A			ne 5 Reside			y)
	lon	1-■Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)		Bc. Inju			8d. Describe ho	w injury occurr	60	
or Attending I after death.  Director: After din by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, tarm, street, tactor		]Yes: 2□I		8f. Location (Sti City or Town		er or Rura	I Route Number,
To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by	edicai (	29a. Certifier de Certifying Physician (Check only one)	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death occurred tion and/or investigation	et the ti	me, date and opinion, deat	d place, a h occurre	nd due to the ca	use(s) and ma ite and place, a	nner es st and due to	lated. the cause(s)
To the Within To the	2	29b. Signature and title of certifier	. 0	29	. Licen:	se number		25	d. Date signed	1 (Month,	Day, Year)
		In Curton	Stoll Menici	an i	19	714			5/29/	99	
		30. Name and address of person who co	mpleted couse of death (Item	23a) (Type, Print)	/		1	0	1 1	0	
		MILYARL FUEL	JHBUML	4940 E	ATTE	Nr 1	Ve	/TAL1,	mur, 1	N/Z	1224
	State	31. Date tiled (Month, Day, Year)	32. Registrar's Signat	ture	1		7				
Reg	istrar	1111 Q	1000 P	~ 17	100	Nal					

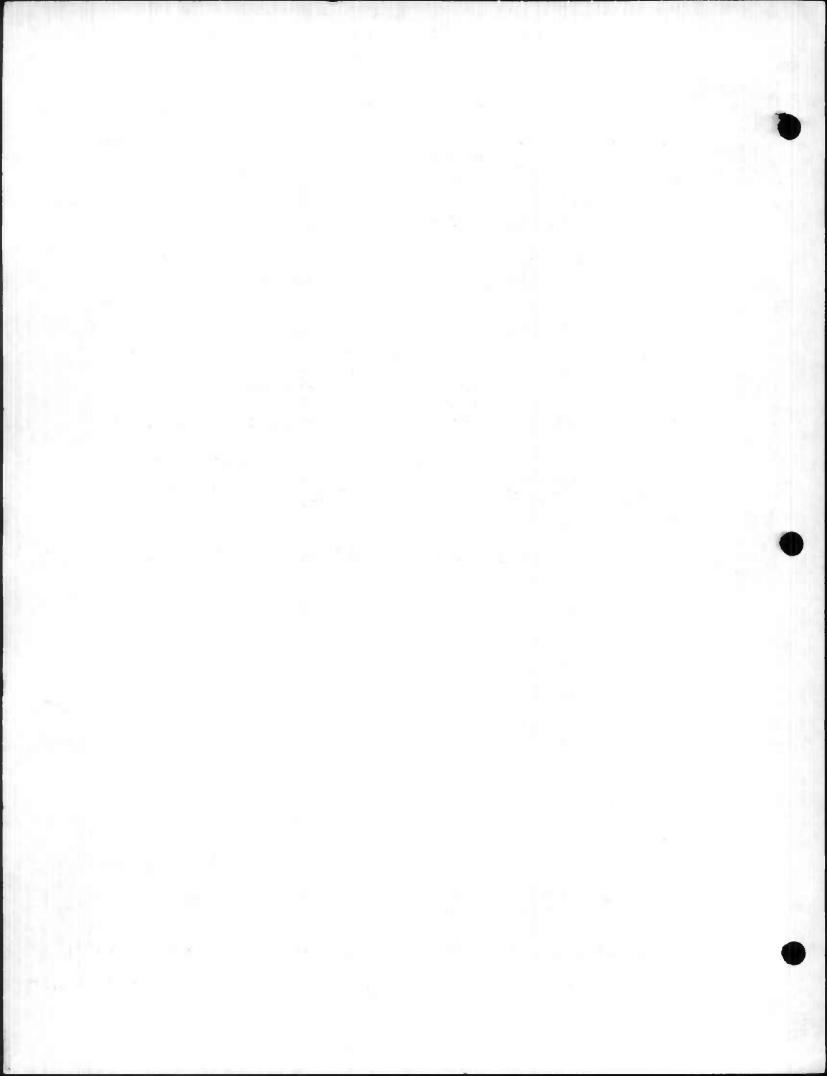
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DHMH 16 Ray 6/95

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_				State of Marylar		tificate of		Re	g. No.	21489
	Physic /Medi		Dacedent's Name (First, Middle, Last)	Margaret		Wida		2. Data of Death Month July 7	Day Year	3. Time of Death 4:30 AM
2	Exami		4a. Facility Nama (If not institution, giva s Eastpoint Nursing				4b. City, Town, or L Dundalk	ocation of Daath	4c. County of Deat Baltimo	
	Funeral Director		5. Social Security Number  219-14-1768  Usual Residence of Decedent	7. Age (In yrs. 92	last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Feb. 2,	Year) 9. Birth Co	hplece (State or Foreign untry) Pa .
poopuoj	f show	or	10a. State 10b. County  F1. Hillsbor		ty, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yas 2 ☐ No
di di	3a or 28a-	ai Director	10e. Street and Number  9620 Lake Pine Place		шра	10f. Zip Code 3363	5	10	og. Citizen of What Co USA	untry?
5-0020	tel thygiene.  do ther than "naturel", or thems 23a or 28a-1 show event, the Medical Examiner (will be notified at	by Funeral		2. Was Decedant Evar in U Armed Forces? 1 ☐ Yes 2 <sup>1</sup> No If Yes, Give Year or Datas:	1f		Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yas or No- Ricen, etc.)	14. Race - Ama Black, White	
121	- 0 40	Completed	15. Decedent's Educ (Specify only highast grade	etion	(Give I	ent's Usual Occu kind of work don OO NOT use retir	during most of work	ding	Own home	
and 2	marked other than	Be	12 17. Father's Name (First, Middle, Last) William John	Paisl		e maker	18. Mother's Nam	a (First, Middle, M		
Mary		To	19a. Informant's Name/Relationship (Type Mrs. Donna Lynn Pro	oe, Print) Grand	19b. Meilin		at and Number or Rui	ral Route Number,	City or Town, State, 2	
Baltimore,	Department of Health a important: If item 27 is any injury or other tra once.		20a. Method of Disposition  1 ☑ Burlal 2 ☐ Cremation 3 ☐ Re 4 ☐ Donetion 5 ☐ Other (Specify)	BILIOVALIIOIII State	Place of Dispos cematery, crem	sition (Name of natory or other pl	ace)	Date 2	Drums, Pa	Town, State
Balti	Departm Importa any inju		21. Signature of Europeal Service Dicease		22. F	Name and Addi		al Home,	Inc.	
	hysiclan /Medical xaminer	14	Part1. Enter the disaase, or complic shock, or heart failure. List only one Immediate Cause (Final disaasa or condition resulting in death)	Athero Sci		Card				Approximate Interval Between Onset and Death
58/5U,	physician and	edical Examiner	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events		or as a consequ					
death certificet	Ç1 60		resulting in death) Last		1 as a consequ	ienos orj.				
7	by th	Physician/M	Part II. Other significant conditions conti	ributing to death but not res	ulting in the un	derlying ceuse g	iven in Part I.			to the cause of death?
UNISION OF VITAL RECORDS, or Attending Physician The law requires the	as been sign 2 should be	Completed by						24a. Was an perform	led?	Were autopsy findings available prior to completion of ceuse of death?
Or Vital		Be	25. Wes case referred to medical examiner?	amitat.				1 ☐ Ye		I ☐ Yes 2 ☐ No
VISION OF		ation: To	27. Manner Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatient 2 ☐ 28e. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju		ome 5 Resider 28d. Describe hor	nce 6 Other (Spec w injury occurred	pify)
Tel or Atte	within 24 hours after death.  To the Funeral Director: After the completaly filled in by the funeral	Certification:	3 Sulcide 6 Could not ba 4 Homicide determined	28e. Place of Injury - At h- building, etc. (Specif	ome, farm, stre	et, fectory, office	}	28f. Location (Str. City or Town,	eet and Number or Ru Stete)	ral Route Number,
Mospi	n 24 house Se Funer Sletaly fill	edicai	29a. Certifier (Check only one)	clan: To the best of my kno er: On the basis of examina and menner stated.	wledge, deeth tion and/or inv	occurred at the t estigation, in my	ime, dete and place, opinion, death occur	and due to the ce red at the time, de	use(s) end manner as te and plece, end due	stated. to the ceuse(s)
<u>\$</u>	withi To th	M	29b. Signature and titla of certifiar	rut Sn M	.0	DE	se number 394660	,	d. Date signed (Month	1999
			30. Name and address of person who com		123a) (Type, F	Print)	n Point	- Red 8	tellimere	MD 2129
	Sta Registr		31. Date filed (Month, Day, Year) 1999	32. Pegistre 9 9 gne	itury 9.	sparks	/			

Registrar DHMH 16 Ray 6/95



r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at

945

death

filed within 72 hours efter

Hygiene.

permit. Pages 1 and 2 should be filed. Department of Health and Mentel hyging Important: If them 27 is marked other any Injury or other traumatic event,

**Physician** /Medical

**Examiner** 

physician end the buriel-transit

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signed by t

page 2 s

certificate

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After

within 24 hours efter deeth.

To the Funeral Director; Al
completely filled in by the fu

To the Hospital of within 24 hours of To the Funeral D

that the death certificate be executed

Box 68760

P.O.

Records,

Division of Vital or Attending Physician;

altimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Hansford Lee Young, III July 04 1999 12:26 PM. /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 5700 Block Pulaski Highway Perryville Cecil If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months **₩** M 2□ F 15 Yrs Director 092-68-1918 July 19, 1983 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Directo Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9405 Indian Camp Road 21045 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stetus 14. Race - American Indien, Black, White, etc. 1X Never Married 2 ☐ Married 1 Yes 2 No Specify: White Specify: P 3 ☐ Widowed 4 ☐ Divorced Year or Detes Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Student Education 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) 8 Hansford Lee Young, Jr. Catherine O'Brien 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Hansford Lee Young, Jr/Father 9405 Indian Camp Road, Columbia, Maryland 21045 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removal from State ur (Specify) Baltimore Washington Cr. 7/8/99 Laurel, Maryland 22. Name and Address of Facility
Fleck Funeral Home, Inc. rice I topos 7601 Sandy Spring Road, Laurel, Maryland 20707 or admplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, List only one ceuse on each line. Approximate Interval Between Onset and Deeth immediate Cause (Fine INJUNIES disease or condition resulting in death) 0/4 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of) Physician/Medical Due to (or as a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed Inspection 1 ☐ Yes 2 No t ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence & Other (Specify) SCENE Hospital: 1₽ Yes 2□ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Neturel 5 Pending 7-4-99 1 Yes 2 No Investigation Subject Struck by Car 281. Location (Street and Number or Rural Route Number, City or Town, Stete) Route 401 West 322 2 Accident 1223 6 ☐ Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Street

Cecil County, Marylano

Cecil County, Marylano

Cecil County, Marylano

Cecil County, Marylano

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. Street edical Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 236) (Type, Print) O.C.M.E. July 5, 1999 Radentz

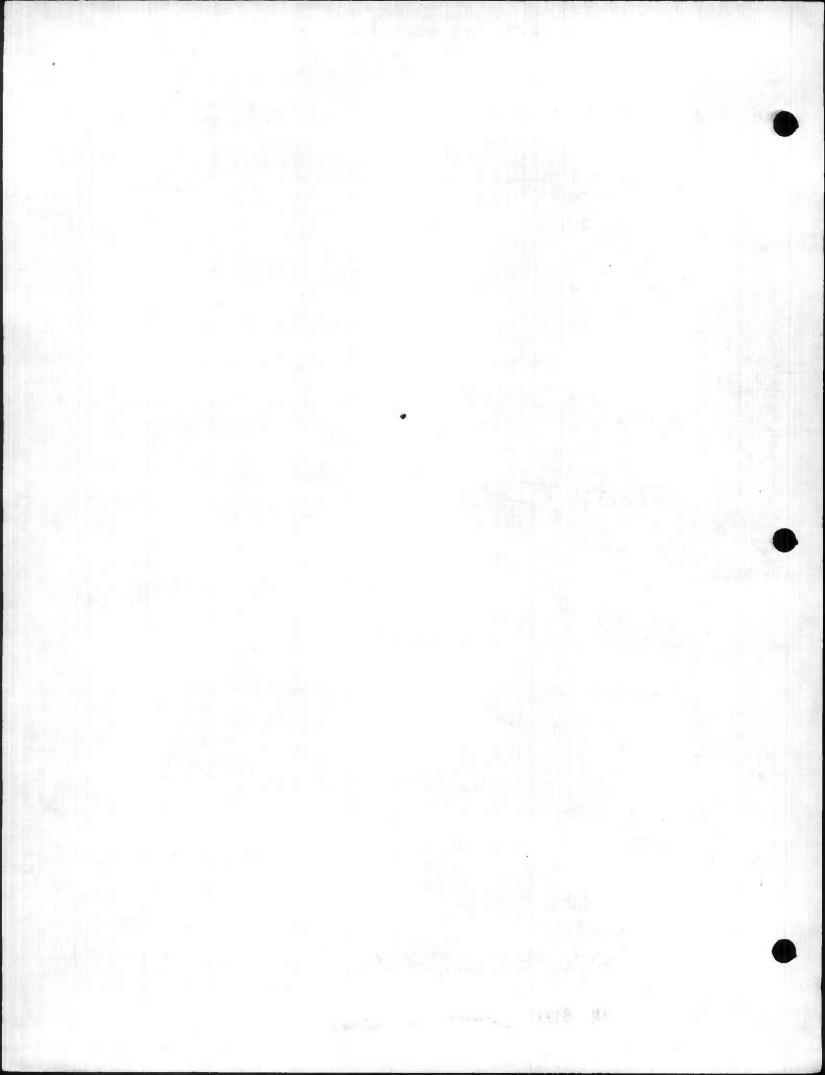
**DHMH 16 Rev 6/95** 

State Registrar Stephen S.
31. Date filed (Month, Day, Year) JUL 81999

32. Registrar's Signature

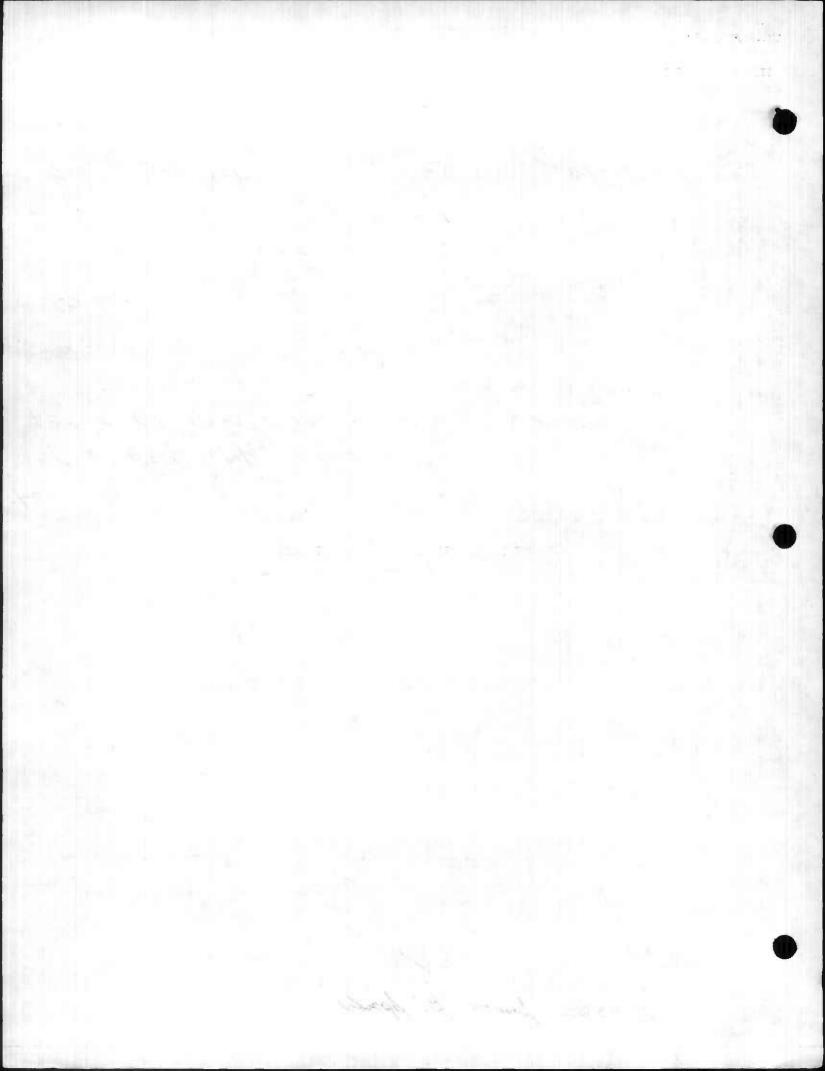
Sporks

111 Penn Street, Baltimore, Maryland 21201



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643-510 NS: #23 P	ART I, 27 PER MEO G773		Certific	ate of	Death	10.0	Reg. No.	lion 1	Time of Day	
Physician		/				2. Dete of De Month	Day	Year	3. Time of Death	
/Medical	CRRANCE  4e Fecility Name (If not institution, give		165		4b. City, Town, or	JUNE	27, 1999		2007 PM	
Examiner							h 4c. County	of Death		
	804 S CLINTON STI		rs. last birthday) If U	nder 1 Year	BALTIMOR If Under 24 Hrs		ath I	O Diebalas	· (Ctota on County)	
uneral irector		20 F	53 Yrs. Morr				2/45	Country	(State or Foreign	
le merked other than "natural", or iteme 23e or 28e-f ahow reumstic avent, the Medical Eseminer must be notified at To Be Completed by Funeral Director	10a. Stete 10b. County	10c.	City, Town or Location					10d.	tnside City Limits	
Examinar must be notified at by Funeral Director	MD		BALTO						18 Yes 2□ No	
Director	10e. Street and Number			Zip Code			10g. Citizen of W	hat Country	?	
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y Funerai	11. Merital Stetus  1 Never Merried 2 Merried	12. Was Decedent Ever in Armed Forces?  1  Yes 2 No If Yes, Give	U,S. 13. Was D		Hispanic Origin? (S van, Mexican, Puer	Specify Yes or No to Rican, etc.)	o- 14. Race Bleck Specify:	- American k, White, etc.		
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0	17. Fether's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle	, Maiden Surname		- CHILLY	
ToB	LIFILSEY FOR	FOH YATE	<del>ک</del> ۲۰		UN	KNOW	N			
_	19a. Informant's Neme/Netetionship (Ty	pe, Print)	19b. Mailing Add	ress (Street	t and Number or Ri	ural Route Numb	er, City or Town,	State, Zip Co	ode)	
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	20a. Method of Disposition	20b	. Place of Disposition	Name of		Date	20c. Location - 0	City or Town	, State	
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dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury									
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y Physician/M	POLIT. Other significant conditions con	veri in Parti.		Yee 2 No						
Completed by	24a. Wes an eutopsy performed?  24b. Were eutopsy findin aveileble prior to completion of cause of death?									
PO						127	Yes 2□No	1,EXY	es 2□ No	
Be	25. Was case referred to medicat				26. Place of De	ath (Check only	one)			
10 8	examiner?	lospital:	☐ ER/Outpatient 3☐	DOA O	her		idence 6 Othe	r (Specify)		
Certification: T	27. Manner of Death 1 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)		28c. Inju Wo			how injury occurre			
Certific	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, street, fac city)	ctory, office		28f. Location ( City or To	(Street and Numbe wn, State)	er or Rurel R	oute Number,	
edicai	29e. Certifier (Check only one) 1 Certifying Physical Cartifying Physical Examination (Check only one)	sician: To the best of my keet. On the basis of examinand manner stated.	nowledge, death occur nation and/or investiga	red at the ti	me, date and place opinion, death occu	e, end due to the urred at the time,	cause(s) and mar date and place, e	nnar as stete	ed. e cause(s)	
M	29b. Signeture end title of certifier	A		29c, Licens	se number		29d. Date signed	(Month, Day	y, Year)	
	1 tonto	A 1/1 m	-1-	0	OME		JUNE 28	. 1999	9	
	30. Name end eddress of person who co	molecular and a significant	C COMP							
				ot P	altimom	Max-1-	nd 21201			
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State Registrar 31. Date filed (Month, Day, Year)

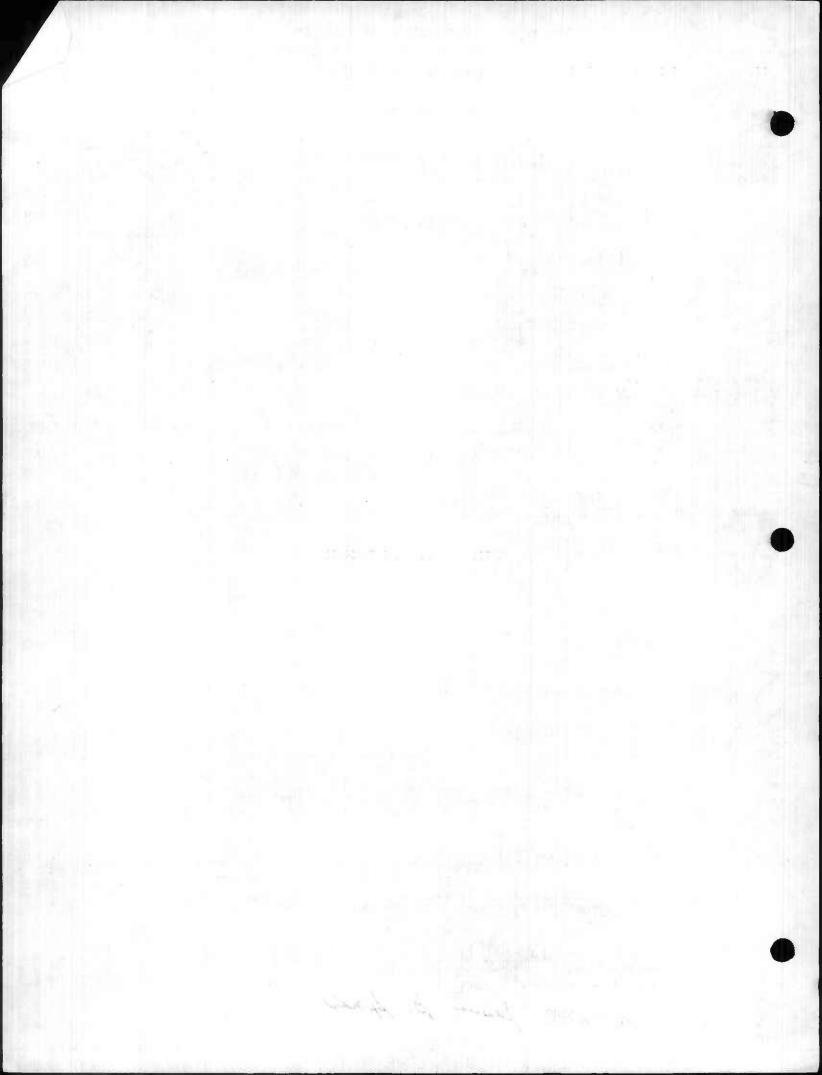
32 Registrar's Signatura

ted cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

July 04, 1999



### Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Florencioz. ALHAMBRA, 21-199 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Laurel Regional Hospital Prince Laurel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 10 M 20 F 269-20-132 Months Days Hours Min 85 Yrs June 22,1913 **Philippines** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limita Prince Georges Laurel 1 ☐ Yes ANO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8807 Montpelier 20708 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 XNo Specify: Specify: Filipino 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Standby Engineer Smithsonian Institute 17. Father'a Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Juan Alhambra Maria Zandueta 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margarita G. Alhambra (wife) same as #10 20b. Piace of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Murial 2 □ Cremetion 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mount Olivet Cemetery 6/25/1999 Washington, D.C. 21. Signature of Funeral Service Monsee 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 MUNIC 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onaet and Death Immediate Cause (Final disease or condition resulting in death) · Myocardial Due to (or as a consequence of): Due to (or as a consequenca of): Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings avellable prior to completion of cause of death? 24a. Was an autopsy performed? Hypertensive heart disease 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpetient 3 DOA

**Physician** /Medicai Examiner

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The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

Examiner

Physician/Medical

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Certification: To

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**Physician** 

/Medical

Examiner

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**Funeral** 

**Director** 

rthan "natural", or items 23a or 28a-f shor the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after deeth 1 Department of Health and Mentel Hyglene. Important: if item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examinal must pense.

Baltimore, Maryland 21215-0020

with the Marylend

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

Toxic encephalopathy

1 Yea 2 No 27. Manner of Death

28a. Date of Injury (Month, Day Year) 5 Pending Investigation

28b. Time of

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

281. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Suicide

4 Thomleide

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end placa, and due to the cause(s) end manner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete and pieca, and due to the cause(a) end menner steted.

29b. Signature end title of certifier acroces Mio.

6 Could not be determined

29c. License number 025775 29d. Date signed (Month, Day, Year)

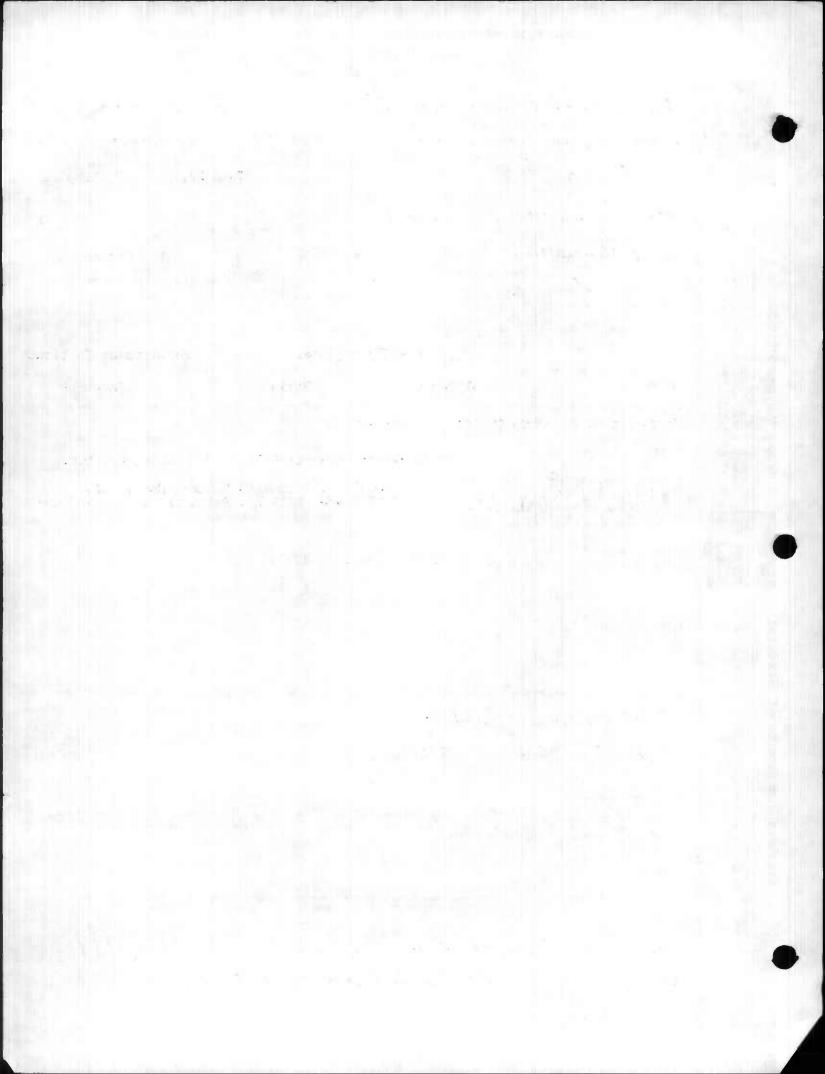
30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)
Lynne Gagnes, M.D; 14201 Laccel fact Drive #214, Laccely MD 20707

Registrar

31. Dete filed (Month, Day, Year)

JUN 2 3 1999

32. Registrar's Signature



### Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death ANDERMAN Month SHIRLEY 3/5PM JUNG 4c. County of Death 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth SUBURBAN HOSPITAL BETHESDA MONTGOMERY If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (Star OCT 13, 1918 NEW YORK 9. Birthplace (State or Foreign Deys Hours 1□M 20 F Months 103-09-0140 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 1 No MONTGOMERY CHEVY CHASE 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 4601 N. PARK AVENUE 20815 USA 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2X No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Specify: WHITE 1 Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry MONTGOMERY COUNTY Elementary/Secondery (0-12) College (1-4or 5+) 5+ TEACHER PUBLIC SCHOOLS 17. Father's Neme /First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) HARRY ROSENTHAL FANNY STERNLIEB 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARTHUR CHOTIN-NEPHEW 5 PINEHURST CIRCLE N.W. WASHINGTON DC 20015 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removei from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 6/24/99 ALEXANDRIA, VA COMFORT CREMATORY 21. Signaturafol Funeral Service Licensee 22. Name end Address of Fecility DANZANSKY-GOLDBERG MEMORIAL CHAPLES, INC 1170 ROCKVILLE PIKE ROCKVILLE MD 20852 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death BRAIN DEATH Immediate Cause (Final diseese or condition resulting in deeth) ANOXIC ENCEPHALOPATHY Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that Initiated events resulting in death) Lest Due to (or as e consequence of): CARDIAC ARREST SIDED HEART FAILURE Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contributa to the cause of death? INTERSTITIAL LUNG 3 Probably 48 Unknown 1 Tas 2 No 24b. Were eutopsy findings aveilable prior to 24a. Was en eutopsy completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Plece of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28d. Describe how injury occurred 28e. Dete of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1-Natural 5 Pending

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/Medical

Examiner

**Funeral** 

Director

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State JUN 25 Registrar

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signeture and title of certifier

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investigation

6 Could not be

of person who completed cause of death (Item 23a) (Type, Print) 49

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Y AVE BETHESDA

Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, end due to the cause(s) end menner as stated.

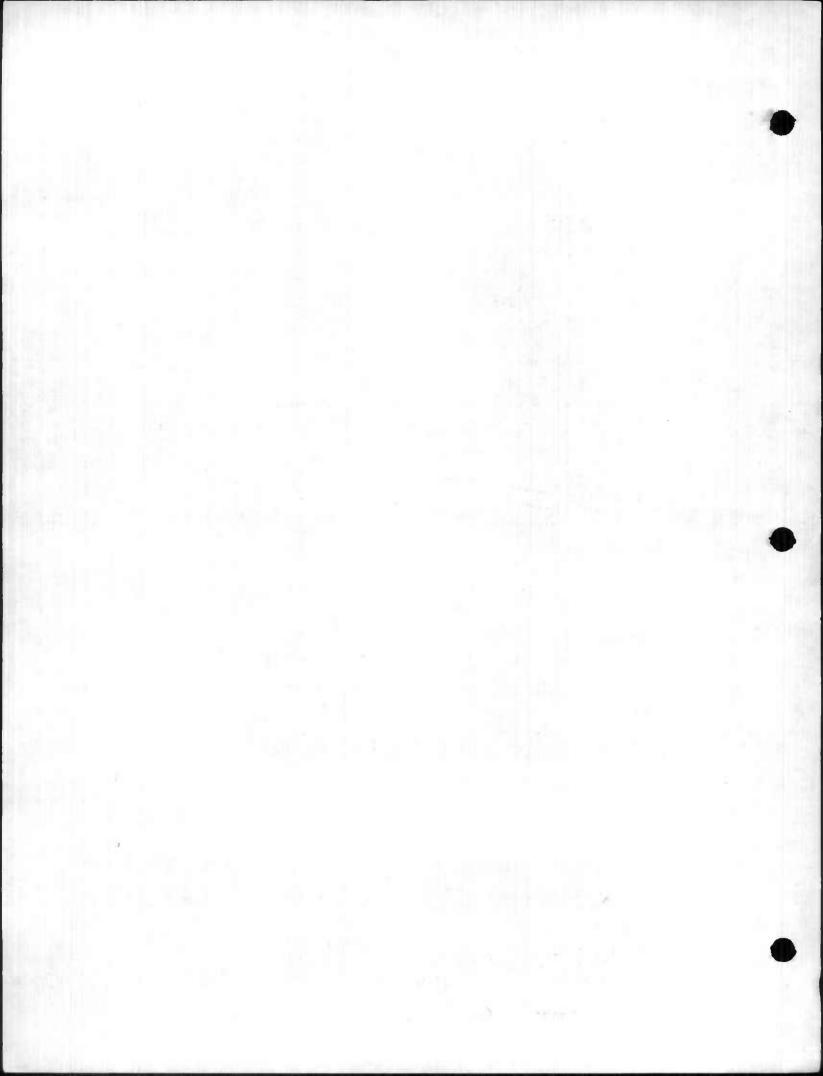
2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s)

29c. License number

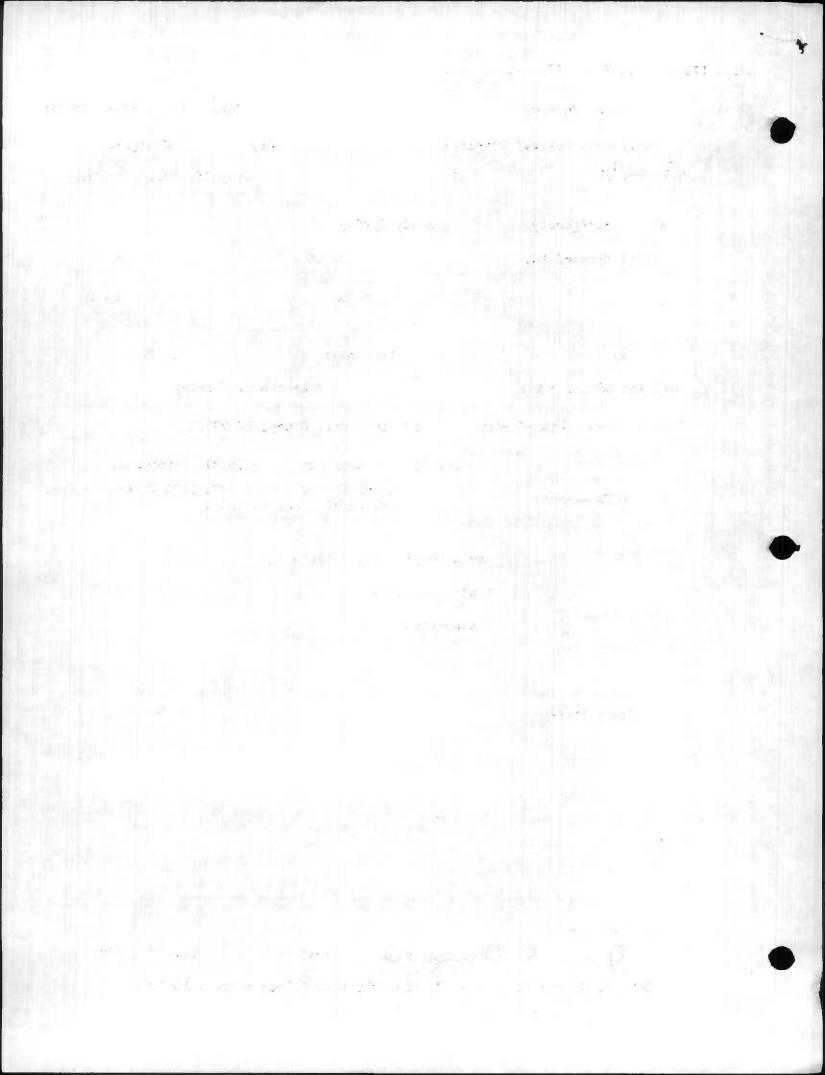
1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Dete signed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene 9 AMEND ITEM: 5 PER F.H. G775 9-29-99 WR. Certificate of Death 1 Decedent's Neme (First Middle Last) 3. Time of Deeth 2 Date of Death Month Physician Lottie Burrows June 1999 16 3:43AM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery General Hospital Montgomery If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) **Funeral** Min Deys 1 □ M 2 🗓 F Yrs. Director 87 July 19, 1911 Virginia Usuel Rasidenca of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 28a-f ahow is marked other than "natural", or items 23s or 28s-f shor traumstic event, the Modical Examiner must be notified at 1 Yes 2 No MD Montgomery Sandy Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 17401 Norwood Rd. 20860 U.S.A Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian, Bleck, White, etc. 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☐ No If Yes, Give X 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify: White If Yes, Give ^ Yeer or Detes: à 3 Widowed 4 □ Divorced Completed 15. Decadent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Own Home 12 Homemaker permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if flem 27 Is marked othe any injury or other treumatic event PAGE. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) William Edward Bowen Leatha T. Fridley 19a. Informent's Name/Ralationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Joan Bowen-Daughter-In-Law 30 Hines Ct., Olney, MD 20832 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Ft. Lincoln Cemetery 6/19/99 Brentwood, MD 21. Signeture of Funeral Service Licansee 22. Neme end Address of Fecility Joseph Gawler's Sons INC, 5130 Wisconsin Ave. NW, Washington, DC 20016 23a. Part1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or health allum. List only one cause on each line. Interval Between Onset and Death **Physician** Immedieta Ceuse (Finel disease or condition resulting in daeth) /Medical Acute Respiratory Failure Examiner Due to (or es e consequence of) Examine Senile Dementia and i-transit The law requires that the death certificate be executed Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Lest Due to (or es e consequença of) physician ar Osteoperosis Box 68760 Physician/Medicai Due to (or es e consequence of): 65 980 P.O. ert. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? signed by 1 ☐ Yes 25 No 3 ☐ Probably 4 ☐ Unknown Contractures Records. P 24b. Were eutopsy findings evelleble prior to completion of cause of death? 24e. Wes an eutopsy performed? Completed peen page 2 certificate has 1 Yes 2 No Division of Vital or Attending Physician: 25. Wes case rafarred to medical axaminer? Be 26. Placa of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No 10 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA this funerai 27. Mennar of Death 28d. Describe how Injury occurred 28e. Dete of injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury et Work? After 5 Panding 1 X Natural 1 ☐ Yas 2 ☐ No after death. Il Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours Hospital edicai 29a, Certifier 1 🔁 Certifying Physician: To the best of my knowledge, daath occurred et tha time, dete and plece, end due to tha ceusa(s) end mannar as stated. 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) end menner stated. (Check only one) within 2. To the F To the 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) ohn D25345 June 21, 1999 Ga 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) John E. Glancy III, MD., 733 Cloverly St., Silver Spring, MD 20905 31. Data filed (Month, Dey, Year) 32. Registrer's Signeture State special Registra JUN 22 1999

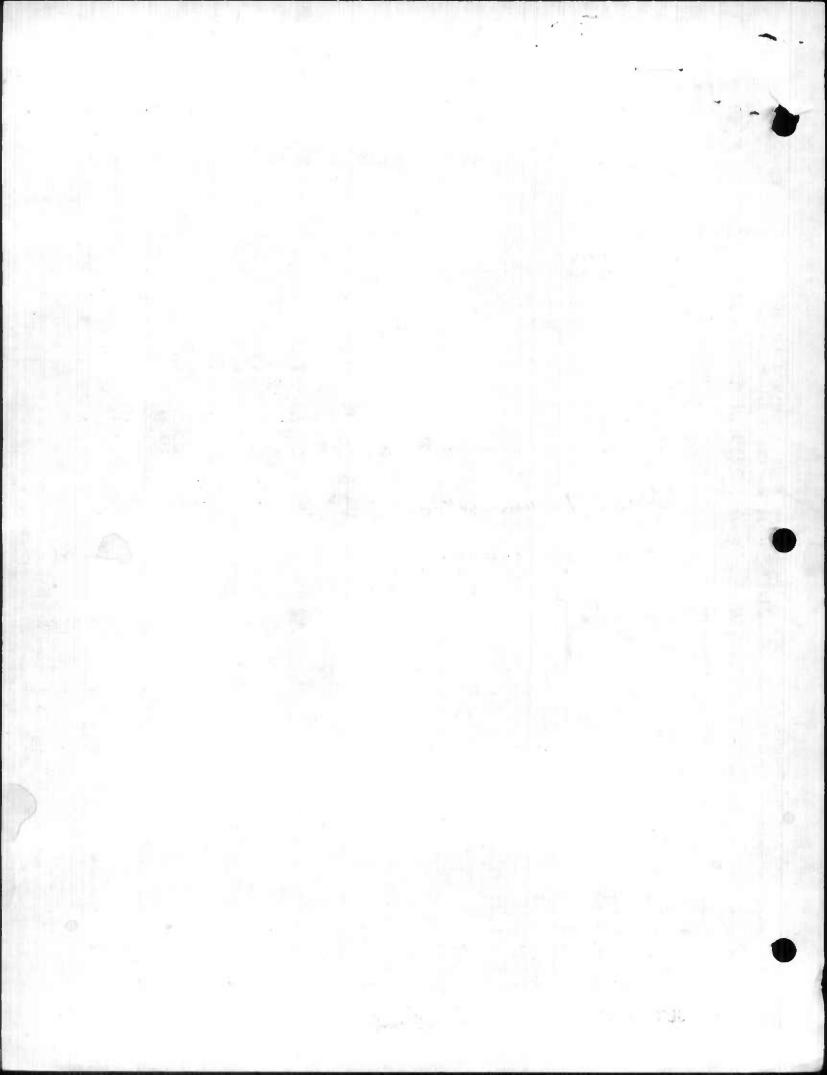


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State of Maryland / Department of Health and Mental Hygiene

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	State of Maryland / Department of Health and Mental Hygiene	99
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49 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** BRAIS NAN A 8.55 0 06 99 · /Medical 4a Facility Nama (If not institution, giva straat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year | If Under 24 Hrs. | 8. Dafa of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex Birthplace (State or Foreign Country) **Funeral** 1□M 2₽F Yrs. Director 90 578-76-0685 MAY 4, 1909 WEST VIRGINIA Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be northed at 1 ☐ Yes 2 No Director MARYLAND PRINCE GEORGE'S WEST HYATTSVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23a and Injury or other traumatic event, the Medical Exemples 2006. 2806 JAMESTOWN ROAD 20782 UNITED STATES Funeral 12. Was Decedenf Evar in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 14. Race - American Indian, Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Ricen, atc.) Black, White, atc. 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify q 3 X Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) HOME MAKER 8 OWNED HOME 18. Mother's Name (First, Middla, Maidan Sumama) 17. Father's Name (First, Middle, Last) 10 HUNTER L. SIPES FRANCES O. CORNELIUS 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15740 FALLING WATERS ROAD, WILLIAMSPORT, MD 21795 RONALD N. BRAIS, SON 20b. Placa of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/23/99 FORT LINCOLN CEMETERY BRENTWOOD, MARYLAND 21. Signature of Funeral Service License 22. Name and Address of Facility
FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722 23. Part Enter the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, thock or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** ACVIL /Medical Immediate Cause (Finet 5626184406 EAICAGE disaasa or condition resulting in death) Examiner Due to (or as a consequence of):

PENAL FAILURE

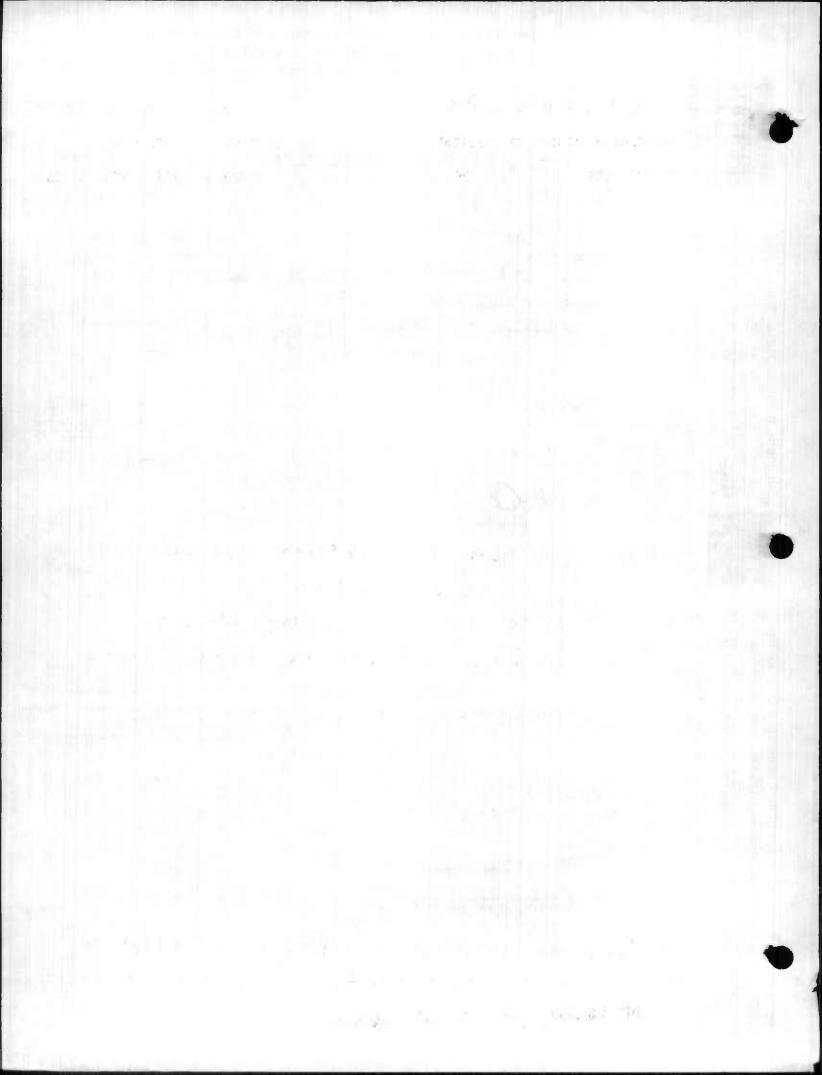
Due to (or as a consequence of): Examiner physician end the buriel-transit Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be execu CON O 153714 E Box 68760, Physician/Medical Due to (or as a consequence of): CIEARU OSENE 98 SCLEROTIC 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t 1 Yes 217 No 3 Probably 4 Unknown 4 + 6 41 C N 51 41 1 by 24b. Were autopsy findings available prior to Completed 24e. Wes an autopsy performed? completion of cause of death? page 2 has 1 Yes AD No 1 ☐ Yas 2 ☐ No certificate Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Plece of Deeth (Check only one) exeminer? 1 Yes 2 No Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury af Work? After 5 Pending Natural after death. Director: Aft 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide e Hospital of 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) end manner as stated.

2 Medical Examinar: On the best of examination and/or investigetion, in my opinion, death occurred at the time, date and placa, and dua to the cause(s) and manner stated. 29e. Certifier Medical (Check only one) pletely To the within 2. 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 181 NO 10 \$230 MAPK MD20912 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. Scoth Holett, MD, 7610 CAPROLE A 7610 State

Registrar

31. Date filed (Month, Day, Year)
JUN 2 3 1999

Pegistrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Catherine Laverne Batson June 20 /Medical 4e. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 25 F 217 60 6002 Yrs. February 27, 1951 WashingtonDC Usual Residence of Decedent 10e. State 10h Counts 10c. City. Town or Location 10d. Inside City Limits 11 Yes 2 □ No Maryland Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5064 Silver Hill Court #103 20747 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Maritel Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Black, Whita, etc. 1 Never Married 2 XMarried 1 ☐ Yes 2 X No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Superviosr District Court of MD 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be Unknown Helen Bernice Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5064 Silver Hill Ct. #103 Forestville, MD 20747 Adrion Batson / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery 6 - 26Lothian, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral HOme -Ouc 4308 Suitland Road Suitland, MD 20746 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death Immediete Cause (Finat RUPTURE MYOCARDIAL disease or condition resulting In deeth) MINUTES Physician/Medical Examiner 36 HOURS 170 CARDIAL FN FARCTION Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last ORONBRY YEAR ( ARTERY Due to (or as a consequence of): MELITUS Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown GASTRO ENTERITIO by 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24e. Wes an autopsy performed? PERCHERGE NEURO PATHT 25. Was case referred to medical examiner? Be 28. Place of Death (Check only one) Hospitat: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how Injury occurred 1- El Vetural 2 □ Accident 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

| Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D31069 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) LANE, #135, LARGO, MD 1100 MERCANTILE E

State Registrar

31. Dete filed (Month, Day, Year) 2 4 1999

32 Registrar's Signature

**Funeral** 

Director

Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

In portant: If Item 27 is marked other than "naturel", or Items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Lakerne

Batson, Catherine

Baltimore, Maryland

Pages 1 and 2 should be nent of Health and Mental

**Physician** /Medical

Examiner

sician and burial-transit

physician is the buria

signed t

page 2

After this certificate

To the Hospital or within 24 hours after death.

To the Funerel Director: After this or market filled in by the funeral directors.

The law requires that the death certificate be executed

Box 68760

P.O.

Records,

Division of Vital

Darbert Connects William

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State Registrar

Physici /Medic Examir

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, to a Medical Examiner must be notified at page.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

31. Dete filed (Month, Dey, Year)
JUN 2 1 1999

30. Name and eddress of person who complete house of deeth (Item 200 (Type, Print)

Alan R. Segal, MD. 1299 Lambenton Dr. Silver Spring, MD. 20902 32. Registrer's Signeture

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ion	ii, Day reai)	injury	М							
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aminer: On the be	asis of axamine	owledge, deeth	occurred vastigetion	at the tim	na, date and pl pinion, deeth o	ace, and	due to the at the time,	cause(s) and made and place,	anner as stated. and due to the cau	B(S)
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